THE UNIVERSITY *of* EDINBURGH

Tales from the Edge:

Sufferers' perspectives of the role of psychotherapy in recovery from anorexia nervosa

Michelle Ramage

PhD
The University of Edinburgh
2013

Contents

APPENDICES

TABLES

FIGURES

Acknowledgements

I would like to acknowledge the support of the following people without which the study and the completion of this thesis would not have been possible. My thanks go to:

- The twelve people who participated in this study for the generosity with which they shared their experiences.

- Colleagues from across Scotland who assisted during the recruitment phase of the study.

- Professor Liz Bondi and Mr Seamus Prior, my supervisors who were unfailing with their support and encouragement.

- The Huntercombe Group who offered financial assistance with this PhD and Diane Whiteoak (Hospital Manager) who gave me the time to devote my energies to the study.

- Elaine Brunger and Michelle Thomas for presentational assistance.

- My husband, Iain, for his patience throughout the entire process.

Declaration

I declare that the following thesis has been compiled by myself, and that the work is my own.

_____

Michelle Ramage

ABSTRACT

As a psychotherapist working in the field of eating disorders, I have a long-standing interest in accessing the subjective expertise of a wider group of sufferers, including what it is like and what it means to suffer from anorexia, the factors that help to support recovery and the role psychotherapy plays in contributing towards the recovery process. This study provides a timely addition to the literature on the nature and role of psychotherapy as a treatment for anorexia. Studies that explore the sufferer's understanding and experience of developing anorexia are extremely limited and a gap exists in examining the role of psychotherapy from the recipient's position and the ways in which psychotherapy supports an individual's recovery process. However, as this thesis demonstrates, people who have suffered and recovered from anorexia hold valuable information on the factors that support recovery and their expertise as recipients of psychotherapy has much to teach clinicians and researchers in the field of eating disorders.

The theoretical foundation of this study conceptualises experience in relation to its narration. I recruited twelve participants drawn from across Scotland who provided narrative data during a focus group and a semi structured individual interview. Participants provided experiential accounts on developing anorexia, on recovery and the role of psychotherapy in their recovery process. A phenomenological approach to data analysis was deployed using Smith et al's (2009) Interpretative Phenomenological Analysis (IPA) as a methodological guide.

Drawing upon an IPA methodology I identified a number of central themes. Within accounts of developing anorexia, themes relating to interpersonal attachment, trauma and/or identity played a central role in the illness beliefs and experiences of participants. Within accounts of recovery, participants offered two main framings. The first defined recovery as an achievable completion point, signally the end of illness. The second defined recovery as an on-going process concerned more with the management of anorexia than the elimination of it. Factors that support recovery included those that are integral to the individual participant as well as those that are made available by their environment.

In accounts of the role of psychotherapy, a number of common factors across participants' experiences of psychotherapy were identified spanning support, learning and action factors. In addition, the quality of the therapeutic relationship with the psychotherapist played a crucial role in supporting the recovery process. I argue that participant beliefs about and experiences of recovery directly relate to their understandings and perceptions about what precipitated anorexia. Recovery took place when changes could be made in relation to these significant themes and psychotherapy was most effective when it addressed these issues as part of the psychotherapy process. The findings from this study point to the importance of working with the subjective understandings and beliefs sufferers have about their illness experience as a key objective within psychotherapy practice. They also underline the significance of a strong therapeutic relationship as a key component of the recovery process.

1 Introduction

1.1 Introduction

Imagine this: You wake up in the morning to someone telling you that you are disgusting. They pinch the flesh on your abdomen, the tops of your arms and run a finger along your side to count how many ribs are protruding. You are scolded that you are "lazy", "fat", and that "you need of take some control of yourself". As you look in the mirror in the bathroom, they tell you how bloated and ugly you look. You are required to make a mental note of everything you ate yesterday, calculate the calorific content and told you need to cut back on eating today if you want to prevent becoming "an ugly, fat pig". In the kitchen, you are instructed to skip breakfast to make up for your gluttony the previous day. You are directed to walk to work, in order to justify having some fruit and coffee at lunchtime. How do you experience these demands? How does this relationship make you think and feel about yourself? Would you want to remain in this relationship?

Now imagine that this other is not a person, but represents something that takes place inside of you. These attitudes and demands are experienced as a running commentary that operates internally. Others cannot hear these critical instructions and punitive remarks. However, they might be able to observe how they influence your behaviour. People in your life might see that you are losing weight, that you eat less or eat differently, that you are more active, more driven. Moreover, unlike an interpersonal relationship that can be terminated, it is far more problematic to disengage from yourself.

The kind of process you have been imagining, first as an interpersonal relationship and next as an intrapsychic process is commonly found in anorexia nervosa. All of the comments or instructions described are examples that people who suffer from anorexia have shared with me. They do not represent, by any means, the most severe or extreme demands that anorexia can place upon the sufferer. Some reach a stage where they are no longer able to take responsibility for their nutritional health, thus requiring hospitalisation for refeeding and other forms of treatment.

This example introduces you to an experience of anorexia from a sufferer's perspective. It is this particular perspective which this study aims to examine in detail. I will begin by introducing the concept of anorexia further and explain the influences which have informed my decision to research the area of personal experiences of anorexia.

1.2 Anorexia nervosa: a quiet killer

Anorexia nervosa is understood and conceptualised in different ways by different people. A dominant conceptualisation of anorexia is of a severe mental health difficulty and I will explore anorexia's categorisation as a mental disorder and the implications of this for sufferers later. Anorexia can run a chronic course for many people (Pike, 1998) and has the highest mortality rates for those human experiences defined as functional mental illness (Vitiello and Lederhendler, 2000; Nielsen et al, 2001). Sufferers tend to die as a result of the physical consequences and complications of starvation and low body weight or as a result of completed suicide (Papadopoulos and Ekbom, 2009). In a review of 108 outcome studies in anorexia, 45% of people recover, 33% show some improvement and 20% of people live with anorexia as an enduring difficulty (Steinhausen, 1999). According to the Office of National Statistics (2000), anorexia affects 500-600 of 11-15 year olds and 1,200 of 15-24 year olds in Scotland at any given time. Approximately 423 new cases are reported in Scotland each year. For those who make a recovery, this is often a slow and arduous process, taking anything between 7-10 years on average (Herzog et al, 1997). Furthermore, there is evidence to suggest that recovery rates have not improved significantly despite ongoing developments in treatment approaches and research into treatment effectiveness (Eckert et al, 1995; Herzog et al, 1996). Given the potential consequences, one might expect that priority would be given to understanding this distressing and disabling condition, to advance interventions that support recovery from it, and ideally, to provide preventative measures if possible.

The current guidelines for the treatment of eating disorders from the National Institute for Health and Clinical Excellence (NICE, 2004) offers generic guidance on issues such as: the assessment and coordination of care; providing information to

sufferers and carers; accessing help early; managing the physical aspects of anorexia; the needs of children and adolescents as well as screening for anorexia and other eating disorders in primary care. However, with very few exceptions, the grading of evidence that informs these guidelines and consequently current treatment is rated as C.

Category C indicates that "directly applicable clinical studies of good quality are absent or not readily available" (NICE, Recommendations Summary, page 4). As a result, the use of expert committee reports, opinions and/or clinical experience of influential leaders in the field have informed the development of these guidelines. The same is true for Quality Improvement Scotland guidance (QIS, 2006), which relies on much of the same evidence, devised by some of the same people.

In summary, these guidelines reflect that the precise causes of anorexia remain unknown and treatment continues to be informed by clinical consensus - in other words by the clinical experiences, perspectives, beliefs and ideas of those who work within the field.

If current treatment models and practices are largely informed in this way, it would seem both in keeping with current methods of generating knowledge and a complementary and expansive step to include the contributions of those of have suffered from anorexia and have first hand experience of it. This is a potentially powerful source of knowledge to help advance understandings of anorexia and how people can best be supported to recover. Indeed, while the physical consequences of anorexia are visible and extreme, the subjective experience of suffering often remains a more hidden and silent process. The uniquely personal process a sufferer goes through has generated many more questions than current research or leading authorities in the field have been able to answer.

I have a long-standing interest in accessing the more hidden subjective experiences of sufferers, including *what it is like* and *what it means* to suffer from anorexia by creating opportunities to hear directly from them. In addition, those people who do recover hold valuable information on the factors that supported their recovery process. This may or may not include treatment experiences, but if it does, it would seem important to better understand from the recipients of treatments what they

perceive to have been helpful and why.

1.3 Personal influences and experiences on the Researcher

I first developed an academic interest in anorexia as a social work student in my early twenties. Having been immersed in learning about the importance of environmental factors (such as interpersonal, social and cultural influences) on health and wellbeing, I was intrigued by the significant over-representation of girls and women with eating disorders and the wide-ranging debates, aimed at better understanding why this might be the case.

The study of anorexia from a social work perspective required an engagement with multiple perspectives, such as biological medicine, psychiatry, psychology, family interactional and sociological perspectives. There appeared to be strongly opposing views regarding the underlying meaning of this form of self - induced starvation.

Immediately after qualifying as a social worker, I began training as an integrative psychotherapist. While my social work training permitted close examination of a broad range of environmental factors that can influence health and illness status, as well as the role of dominant cultural and political views in shaping understandings of certain types of behaviour and ways of relating, my psychotherapy training explored the relationship between the person and the environmental in more depth. This included exploring both inter- and intrapersonal dynamics and the effects of each on health and wellbeing. Learning about models of cognition, behaviour, affect and physiology influenced my understanding of anorexia further. I became interested in the types of psychological processes involved in anorexia. This interest has persisted and influenced my decision to work as a psychotherapist and manager within a specialist eating disorders inpatient setting, where I have worked for the last 8 years.

Within the inpatient setting, I have worked with many people (mostly female) who have engaged in individual psychotherapy as part of their treatment. Some have gone on to recover and some have not. With each person, I have aimed to listen to his or her subjective experience of suffering from anorexia when collaboratively

developing a psychological formulation. The psychological formulation seeks to identify factors that may render an individual vulnerable to develop anorexia, the issues that may precipitate the onset of anorexia, as well as those that maintain it over time.

As part of my own practice, I have observed that people who develop eating disorders often have specific views and perceptions about the predisposing, precipitating and perpetuating factors involved in their eating difficulties. Within the context of a trusting therapeutic relationship, sufferers regularly narrate personally meaningful ideas about what triggered their difficulties with food and eating and why they have been sustained. These are rarely limited to concerns about weight and shape, and are more frequently situated within the broader context of their lives. In my day-to-day practice as a psychotherapist I have heard intimate accounts of varying forms of family difficulties, traumatic experiences including physical and sexual abuse, personal struggles with growing up and the formation of self-identity. I have repeatedly heard how these difficult experiences are mediated and managed by establishing a particular type of relationship with food, eating and the body. For example, when one sufferer told me she intentionally starved herself to orchestrate admission to hospital and thereby distance herself from a family member who was sexually abusing her, her weight loss was understood as a purposeful action seeking to secure her own safety. Similarly, when another sufferer said she restricted her dietary intake and became "unwell" because being "ill" was the only way she believed she could activate concern and support from her busy parents, the meaning of her anorexia was understood as purposeful action aimed at securing consistent care.

In summary, the people with whom I work regularly narrate subjective meanings about their weight and shape concerns and the employment of dietary restriction and other weight loss strategies. Through the process of developing a psychological formulation, person-centred goals are identified that directly inform the tasks required in psychotherapy. The psychotherapeutic work places centrally the meanings that sufferers have about weight, shape and eating, as well as the beliefs they hold about the self, others and the world.

However, given the limited knowledge base on causes of and treatments for anorexia, clinical practice, including the provision of psychotherapies, tends to differ across treatment centres. I have therefore reflected on whether the subject meanings sufferers' possess about weight, shape and eating is specific to or arising from my psychotherapy practice, or perhaps more accurately, the psychotherapeutic practice that has developed within my place of work. I have pondered if this relates to something particular or unique about people who are referred to specialist inpatient treatment. Alternatively, I have questioned whether sufferers' from different parts of Scotland, who have received treatment elsewhere, also possess important meanings and perceptions about their experience of developing and recovering from anorexia. I have sustained a curiosity about whether subjective meanings are addressed within psychotherapeutic work elsewhere and more generally about the ways in which psychotherapy contributes towards sufferers' recovery. This question has contributed to my interest in hearing from people from across Scotland who have suffered from anorexia and undergone psychotherapy in a range of different therapeutic settings.

1.4 Overview of Chapters in this thesis

In Chapter Two, I review the literature pertaining to developing anorexia, recovery, and the role of psychotherapy in a sufferer's recovery process. To achieve this, a broad range of perspectives are examined including psychological, social, biomedical and subjective understandings of anorexia. This examination identifies areas of comprehensive research activity as well as highlighting significant gaps within knowledge production and important perspectives that are underrepresented within the field of eating disorder research.

It also orientates the reader to a number of central concerns. This includes the significant differences in conceptual understandings of anorexia and in the practical implementation of how best to support those who suffer from it. Despite a general trend towards more multi-dimensional and multi-disciplinary understandings of anorexia, I argue that many schools of thought remain passionate and somewhat territorial about their own particular perspectives. Within this competitive academic and clinical context is an alarming under representation of sufferer perspectives,

particularly those which explore the lived experience of anorexia. In addition, research which explores recovery from anorexia is also problematic given significant discrepancies in how recovery is defined and measured. This fundamental issue makes an examination of the recovery literature complicated and the findings derived from it unclear. Furthermore, research that explores the role of psychotherapy in recovery is extremely limited and studies that explore sufferer perspectives on how psychotherapy helps people in their recovery process is conspicuous in its absence, particularly when psychotherapy is seen as a fundamental aspect of treatment. As a result, this review of the literature provides a rationale for the aims of this research and influences the specific research question that this study seeks to address.

Having established the research question, in Chapter Three I address some of my philosophical and theoretical assumptions as researcher. In particular I explore my assumptions about the nature of lived experience and how our lived experiences are represented and understood by other people - for example, by a research participant and a researcher. Within this study, I posit that lived experience is knowable, both to the self and others. Experience can be knowable to the self through thoughts, feelings, bodily sensations, perceptions, memories, and beliefs. Experience can be knowable to others through the process of representation and interpretation. Representation refers to the ways we can share our lived experiences with those around us. Interpretation involves the tools we have available to get closer to, understand and make sense of the experiences of others. I believe that narratives are one way that we are able to represent our lived experiences. They are available to be interpreted intellectually and emotionally. In other words, narratives speak to 'the heart and mind'. Deploying cognitive processes, we can seek to understand what an experience might *mean* to the teller. Deploying empathic processes, we can seek to imagine what the experience might *feel like* for the teller.

These philosophical and theoretical assumptions inform the choices and rationale for the research design. A qualitative approach was selected with particular aims to draw upon subjective narratives of developing anorexia, recovery and the role of psychotherapy. To elicit narratives, I use semi-structured individual interviews. Narrative representations are then interpreted using Interpretative Phenomenological Analysis (Smith, 1996) as a methodological guide.

In order to recruit participants with personal experience of anorexia, this study required NHS Multi-Site ethics approval. This process addressed the ethical issues pertaining to the prevention of harm to potential or actual participants. Ethical considerations have been at the centre of decisions about the design and implementation of this research and are discussed throughout the thesis.

Having explored the methodology of this study, chapters Four, Five and Six explore the main findings. To structure information in a way which maximises clarity and transparency, each chapter is devoted to one of three areas of investigation. Chapter Four is devoted to findings on Developing Anorexia. Participants tell powerful stories about developing anorexia and create particular meanings about causation. Three broad themes are identified from the data. These themes represent my interpretation of participants' underlying beliefs and perceptions about significant factors in the development of their eating disorder.

Chapter Five is devoted to findings on Recovery. Within this chapter, participants' definitions of recovery are explored, including understandings about whether it is ever possible to make a complete recovery as well as the factors that can meaningfully support recovery or assist in managing anorexia over time. I identify and discuss an important thread running through participants' accounts of developing anorexia and recovery - specifically that recovery seems to involve attention to or support with the issues that participants define as significant factors in developing anorexia.

Chapter Six is devoted to findings on the Role of Psychotherapy in recovery from anorexia. In this chapter, I explore common factors across a range of different psychotherapy modalities and share further connections between subjective understandings of developing anorexia, the process of recovery and the way psychotherapy aided this process. I argue that individual psychotherapy is perceived as helpful precisely when it addresses one or more of the three themes linked to the development of anorexia. By attending to or supporting the sufferer with the issues that they perceive to be significant in developing anorexia, this contributes towards the recovery process. I also pay attention to the therapeutic relationship in psychotherapy

and the factors that serve to make the relationship helpful, healing and supportive.

Finally, in Chapter Seven, I bring together the main findings from this study and how these relate to existing literature. I discuss what this study adds to knowledge in the field of eating disorder research and explore the implications of the findings for psychotherapy practice and eating disorder treatment in general. I also highlight the limitations of this study and seek to situate this study ethically within available literature, as well as pointing towards areas for future research.

2 Literature Review: Mapping the Theoretical Terrain

2.1 Introduction

In Chapter One, the current status of knowledge and knowledge production relating to both the aetiology and the treatment of anorexia was introduced. Central to these issues is the lack of clarity and consensus in both areas, and continued uncertainty about what will best help sufferers to make a recovery. I declared the important influences on my interest in the field and my persisting ambition to access more intimate and subjective understandings of what it is like to suffer from anorexia and the sense sufferers make of why this might have happened to them. Moreover, for those sufferers that make a recovery, it would be valuable to understand what helped them in that process - for example, if recovery was influenced by treatment experiences, such as the provision of psychotherapy, by factors outside of treatment experiences or a combination of both.

These broad questions have informed my review of the literature. This has included reviewing dominant debates and understandings on developing and recovering from anorexia, requiring inclusion and exploration of perspectives from multiple schools of thought. This includes psychiatric, family interactional, psychological and psychotherapeutic, medical and sociological perspectives. Some of these disciplines sit distinctly from the others, some hold fundamentally opposing views, although more recent literature reflects increased theoretical rapprochement and a movement towards an integration of perspectives.

However, given my particular interest in exploring subjective views from sufferers, which is consistent with a qualitative research paradigm, I will focus in more detail on studies which explore the issues surrounding developing anorexia, recovery and the role of psychotherapy from sufferers' perspectives.

I will begin the literature review by offering a historical overview to help situate current definitions and understandings of anorexia (*2.2*). I will then explore some of the prominent debates on the aetiology of anorexia from medico-clinical (*2.3.1*); socio-cultural (*2.3.4*) and sufferer perspectives (section *2.4*).

Next, I will review the literature on recovery from anorexia. This will include an examination of academic and clinical definitions of recovery (*2.5*), an overview of sufferers' accounts of recovery (*2.5.2*) and a discussion of the available literature of recovery from anorexia from sufferers' perspectives (*2.5.3*).

Following this, I will explore available literature on the role of psychotherapy in the treatment of anorexia. This will involve reviewing a range of debates about the role of psychotherapies for anorexia, highlighting some of the main psychotherapeutic modalities being offered to sufferers and the status of particular psychotherapeutic approaches within the literature (*2.6*). Finally, I will review available literature from sufferers' perspectives on the role of psychotherapy and/or experience of psychotherapy in recovery from anorexia (2.7). Finally, I will discuss the literature reviewed and share with the reader how this has assisted in the refinement of the focus of this study (*2.8*).

2.2 Defining Anorexia Nervosa

The term anorexia comes from the Greek for 'loss of appetite', although the term is somewhat misleading as the restriction of food intake associated with anorexia does not result from a loss of appetite, in the sense of the absence of hunger. Instead, dietary restriction relates to an intense fear about the effect of food and eating on the sufferer's weight and shape. The psychiatrist Gerald Russell was responsible for the first diagnostic descriptions of anorexia in 1970, which became the basis for diagnostic criteria, set out in DSM and ICD classifications. DSM is the American diagnostic system, whereas ICD is an international classification system, widely used in Europe, including the United Kingdom. The original three criteria contained in the Diagnostic and Statistical Manual- III (1980) were:

1. Behaviour that is designed to produce marked weight loss;
2. A morbid fear of becoming fat, which is the characteristic psychological disturbance; and
3. Evidence of an endocrine disorder which in the post-pubertal girl causes the cessation of menstruation.

All three features had to be present to fulfil diagnostic criteria. However, the third feature was eventually changed due to a revised understanding that cessation of menstrual function is a secondary outcome of the effects of starvation in post-pubertal girls.

The original three criteria were developed to form the current diagnostic criteria set out in both the Diagnostic and Statistical Manual IV TR (2000) and International Statistical Classification of Diseases and Related Health Problems, tenth revision-ICD-10(1992) standards. To fulfil criteria, all features must be present for a three month period. Both sets of diagnostic criteria are set out in Table 1.

Table 1: Diagnostic descriptions of Anorexia Nervosa

DSM-IV TR Diagnostic criteria	**ICD-10 Diagnostic criteria**
Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to maintenance of body weight less than 85% of that expected, or failure to make expected weight gain during period of growth, leading to body weight less that 85% of that expected).	Body weight is maintained at least below 15% below that expected (either lost or never achieved), or Quetelet's body mass index is 17.5 or less. Pre- pubertal patients may show failure to make expected weight gain during the period of growth.
Intense fear of gaining weight or becoming fat, even though underweight.	The weight loss is self induced by avoidance of "fattening foods" and one or more of the following: self-induced vomiting; self-induced purging; excessive exercise; use of appetite suppressants and/or diuretics.
Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight and shape on self-evaluation, or denial of the seriousness of current low body weight.	There is body image distortion in the form of a specific psychopathology whereby a dread of fatness persists as an intrusive, overvalued idea and the patient imposes a low weight threshold on himself or herself.
In post-menarchal females, amenorrhoea, i.e., the absence of at least three consecutive menstrual cycles.	A widespread endocrine disorder involving the hypothalamic-pituitary gonadal axis is manifest in women as amenorrhoea and in men as a loss of sexual interest and potency. (An apparent exception is the persistence of vaginal bleeds in anorexic women who are receiving replacement hormonal therapy, most commonly taken as a contraceptive pill). There may also be elevated levels of growth hormone, raised levels of cortisol, changes in the peripheral metabolism of the thyroid hormone, and abnormalities of insulin secretion.
	If the onset is pre-pubertal, the sequence of pubertal events is delayed or even arrested (growth ceases; in girls the breast do not develop and there is primary amenorrhoea; in boys the genitals remain juvenile. With recovery, puberty is often completed normally, but the menarche is late.

The other main differences in these diagnostic descriptions relate to the number of eating disorders listed in each. DSM IV TR lists three eating disorders, whereas ICD-10 lists eight. DSM IV TR also further differentiates anorexia nervosa to specify a binge/purge subtype, where binge eating or purging behaviour such as self-induced vomiting, the use of laxatives and/or diuretics is evident and a restricting subtype, where the behaviours previously described do not feature and weight loss is primarily achieved through dietary restriction (Diagnostic and Statistical Manual IV TR, 2000).

Both diagnostic systems raise important issues. They illustrate the ways in which diagnostic criteria can differ between geographical locations and are revised and altered over time. In other words, they are fluid constructs devised by influential professionals who work in the field. Furthermore, they represent socio-political activity influenced and shaped by social context. This includes the rise of psychiatry in understanding and labelling human experience and the power base psychiatric medicine has carved out in contemporary society. Indeed, the development of these diagnostic systems is a relatively recent enterprise and it is only in the last 40 years that anorexia has been formally categorised as a mental illness. Two important questions arise from this. First, is anorexia a relatively new phenomenon? Secondly, what are the possible implications for sufferers that anorexia has been defined as a mental illness?

Starting with the first question, anorexia has been described, albeit using different definitions and understandings, throughout history. It was first described by Morton in 1694 as a "nervous consumption", by Whytt in 1764 as "nervous atrophy", by Macre in 1860 as a "hypochondriacal delirium", by Lasegue in 1873 as a "hysteria linked to hypochondriasis" and by Gull in 1880 as a "perversion of the ego" (cited by Silverman in the *Handbook of Eating Disorders: Theory, Treatment and Research* 1995, page 26). By the late nineteenth century anorexia was beginning to be formulated as a psychiatric condition. However, from the turn of the century until the 1930s, few cases were reported. For a time, it was thought that anorexia might be associated with Simmonds disease, a condition associated with a pituitary cachexia involving abstinence from food.

By the 1950s, an alternative view of anorexia was offered by Hawkings et al (1956) in the *British Medical Journal*. They conceptualised people who refused food within a category of "deliberate disability" (page 361). During this period, self-inflicted injuries

were seen as manifestations of psychopathology, and the refusal of food and subsequent weight loss were conceptualised as a form of deliberate self-harm. However, a growing number of academics, researchers and clinicians were starting to notice and become interested in the effects of social conditions on mental health and wellbeing. Some went on to argue that conditions such as anorexia were intrinsically related to the social aspects of the person's life, that the hypothesis of an underlying "disease" could not be proven, nor would this help inform how best to help people in distress to move towards health and wellbeing (for example, Laing, 1964, Szasz, 1971, 1972, and Goffman, 1968).Socio-cultural perspectives continued to develop, presenting a challenge to medico-clinical understandings of anorexia.

In his essay, 'Anorexia Nervosa through Time', Russell (1995) argued that diseases change over time, including symptoms and the people who experience them. He argued that the "modern expression in our anorexic patients who speak of their dread of fatness is entirely consistent with today's cult of thinness" (page 9). If one accepts Russell's fundamental position on the pathoplasticity of mental illness, then presumably anorexia will continue to change. While this may be the case, an additional and/or alternative explanation relates to the ways in which people aim to understand and make sense of complex human behaviours, particularly those which operate outside of the prescribed norms of contemporary society. For example, to say that diseases change implies that understandings about the disease are complete and correct. I would argue that the sense we make about human experience, including mental health difficulties, can only be understood within the available constructs we have to draw upon. As those constructs change, so does our understanding of what the disease or illness is. In other words, it is not necessarily only the disease or illness itself which is malleable, but the range of influences that shape and inform the way we might understand it.

In summary, anorexia is not a new phenomenon but the conceptualisation of it as a functional mental illness is relatively recent. While some academics, clinicians and researchers view the dynamic and fluid shifts in diagnostic categorisation as a relatively unproblematic enterprise, others contest this view and critique the revision of psychiatric and diagnostic criteria as a contradiction to its roots in essentialism. Accordingly, others view the activity of psychiatric classification and the revision of diagnostic criteria as a

profoundly socio-political enterprise aimed at securing the ownership of certain kinds of human experience within the domain of psychiatry.

Moving to the second question, the categorisation of anorexia as a mental illness has profound implications for sufferers. Firstly, the diagnostic label defines and potentially confines the thoughts, feelings and behaviours of people as expressions of illness, as psychopathology. Although Russell alluded to the influence of social factors in the causation of anorexia, the fact that all people are exposed to these social factors, such as the "cult of thinness", underlines an area of deficit or defectiveness in the individual who then goes on to develop a mental illness (anorexia) while other people do not.

Secondly, the conceptualisation of anorexia as a psychiatric condition and not, for example, a representation of something many or most people are preoccupied with, i.e., weight and shape concerns, means there is a degree of ownership of anorexia by the medical and psychiatric community, whose business it is to identify causes and develop treatments. While this may represent an advantage for some sufferers who wish to have their subjective experiences formulated within a medico-clinical framework and have treatments offered accordingly, it may equally represent a disadvantage for other sufferers who feel alienated and marginalised by the pathologising of their personal suffering.

Moreover, the ownership of anorexia by the medical and psychiatric professions has not yielded significant advances in knowledge about the causes of anorexia or the best forms of treatment aimed to support recovery. For example, in 1970 Russell wrote:

> No clear-cut causes for anorexia nervosa have yet emerged, but data are being accumulated from more precise fields of enquiry – applied psychology, family studies, endocrinology, and nutritional physiology and chemistry (page 131).

However, in 2006, Palmer stated:

> It is perhaps 40 or so years since the truly modern concept of the disorder came to be established through the work of such authors as Hilde Bruch, Arthur Crisp and Gerald Russell. And still after all this time, the

> management and treatment of the disorder remains unsatisfactory in most respects (page 5).

Returning to the issue of diagnostic systems, more recently Fairburn (2008) fundamentally challenged the diagnostic classification of eating disorders in his proposition of a transdiagnostic perspective. He suggested:

> the way eating disorders are classified encourages the view that there are a number of distinct conditions, each requiring its own form of treatment. There are strong reasons to question this stance (page 7).

Fairburn highlighted that anorexia nervosa is the rarest eating disorder, comprising only 10-15% of the outpatient population, with bulimia nervosa making up about 30% of cases, and eating disorder NOS (not otherwise specified) making up between 50-60% of adult outpatients. He continued that there is arbitrariness in the way eating disorders are defined to create these three diagnostic concepts. Fairburn stated:

> What is most striking about anorexia nervosa, bulimia nervosa and eating disorder NOS is not what distinguishes them but how similar they are (page 10).

He suggested that in practice, sufferers often experience a range of symptoms that incorporate criteria of all three eating disorders. Rather than assume a recovery from one and development of another type of eating disorder, Fairburn continues to describe eating disorders as a fluid trajectory of symptoms characterised by the emergence and subsidence of various difficulties and concerns over time. This is an influential perspective, yet current diagnostic criteria, which tend to separate and cluster symptoms continues to be used.

In order to explore the issue of developing anorexia further, I will now discuss some of the prominent debates that exist within and across medico-clinical and socio-cultural perspectives before reflecting on the current status of them.

2.3 Developing anorexia: Perspectives on aetiology

2.3(1) Medico-clinical approaches to developing anorexia: Prominent contributions

Arising from the categorisation of anorexia as a mental illness, a sufferer's concerns about weight and shape and associated behaviours have been conceptualised as largely psychologically driven. Both Hilde Bruch and Arthur Crisp were highly influential in formulating how we understand anorexia from a psychological perspective.

Hilde Bruch first described anorexia in 1974 as "a relentless pursuit of thinness". This pursuit is motivated by the individual's need to experience his or her own self-discipline and self- denial. The function of this experience, through the control of food intake, provides a mean by which the sufferer can experience a personality core. For Bruch, the central difficulty for the sufferer is a problematic self identity. She stated:

> They suffer from a deep fear of being incompetent - a "nothing" and of not getting or even deserving respect. They are *de facto* deficient in their awareness of their core identity, in their sense of autonomy and in their ability to make decisions about the future (1985, pages 10-11).

Bruch suggested that anorexia has three areas of disturbed psychological functioning:

1. Body image concerns. This includes thinking and expressing the perception of being fat when the sufferer is thin and inaccurately compares his or her body size with others;
2. Difficulties in being able to accurately identify bodily stimuli, including hunger. Such bodily stimuli are not "innate biological knowledge", and must be learned and subsequently "organised into recognisable patterns" (1969, page 93). She accounted for a failure to learn when a child's caregiver does not recognise and respond appropriately to the child's needs. She viewed problematic and essentially dysfunctional interpersonal patterns as a key causal factor in developing anorexia. For example, failing to respond to the child's initiated cues (of which feeding is one example), the child does not gain a sense of control or mastery over bodily sensations. This results in a developing a sense of ineffectiveness, and

3. "Ego deficiencies" in adolescence means experiencing life as something that is controlled by others (1969, page 100). Bruch also described this as an "incomplete sense of separateness" (1985, page 13). This coupled with the emergent development task of gaining independence results in the anorexic adolescent utilising the body as the medium to experience some sense of control and mastery. Bruch located the development of "ego deficiencies" in "the abnormal patterns of family interaction" (1978, page 106). The adolescent sufferer, frequently described by family members as successful, co-operative, and well-behaved is not offered a sense of being unconditionally valued. The individual is praised for what they do, not for who they are. According to Bruch, the sufferer resents this parental over-control and manipulation and would ultimately prefer "to starve themselves than continue a life of accommodation" (1978, page 48). The function of anorexia is an attempt at acquiring interpersonal independence and control over the body.

For Arthur Crisp, anorexia was "a phobic avoidance stance", "a disturbed biological solution to an existential problem for an adolescent" (Crisp, 1980). Like Bruch, Crisp conceptualised anorexia as an adaptive position. However, he argued that anorexia represents a "psychobiological regression" (1974, page 530), a "flight back into psychobiological childhood" (1970, page 454). The adolescent is protected from the "maturational crisis" of puberty (1979, page 63), which is experienced as overwhelming. The phobic fear is not of food, but of *fat* which actually describes normal adolescent body weight. It was the control of weight and shape that was central for Crisp and the only significance of food in anorexia emerges from its direct connection to shape and weight (1977).

Crisp suggested that anorexia develops either from the adolescent's individual difficulties, from the family's difficulties or from a combination and interaction of both. He wrote:

> First anorexics' families can be pathological in a variety of ways; and second, it can be the anorexic herself who is deficient in some way: anorexia can be caused either by the two acting together, or by the second alone (1977, page 66).

Crisp also made socio-political comments on the role of society in adolescent development. He argued that puberty presents an "existential challenge" to the developing adolescent (1980, page 48). The development of secondary sexual characteristics is profoundly significant biologically and socially; biologically as it is indicative of reproductive capability and socially as it arouses sexual interest from others. The relationship this has with eating is the biological and symbolic fusion with sexuality, procreation, and continued maturation.

For Crisp, the social aspect of puberty and adolescence had two distinct factors:

1. The adolescent must develop "in ways adaptive to the available social matrix" (1980, page 49). That is, to find ways to experience some degree of belonging;
2. Adolescents in contemporary society are prescribed with permissive guidelines for social behaviour. Crisp described this as "philosophical and moral uncertainty and bankruptcy" (1974, page 530). He argued that this results in the need to organise consistent and reliable structures and controls *internally*.

Crisp also attended to the role of the family in the development of anorexia. Not only is there an "adolescent maturational crisis", a "family maturational crisis" can also occur (1979, page 151). Crisp outlined how the adolescent's issues of emerging independence and sexual development can provoke a reaction in his or her parents. Such a reaction can be based upon their own unresolved conflicts about self-identity, sexuality and sense of social significance. In 2006, Crisp continued to defend his view that anorexia is a phobically-driven biologically-based avoidance mechanism, rooted in the pubertal/reproductive process. He argued that the intensity of anorexia, coupled with the underlying maturational challenge driving the phobia, governs the natural history of the condition and its prognosis.

Both Bruch and Crisp were influential in promoting perspectives on systemic, interpersonal and intrapsychic processes in the aetiology of anorexia, specifically highlighting developmental processes and the complexities of identity-formation within problematic familial and social environments. Their views were also informed by the work of Minuchin, which offered a new conceptual model of anorexia. His concept of the 'psychosomatic family' placed emphasis on pathological interactive processes

between members of a family system as a significant causal factor in the development of anorexia (Minuchin, 1978). Minuchin suggested that the sufferer of anorexia both experiences and expresses "symptoms" directly associated to difficulties within the family system. Therefore anorexia is an expression of systemic not individual pathology.

Authors such as Bruch (1973, 1978), Palazzoli (1978) and Masterson (1977) developed these systemic ideas by exploring the link between attachment disruption in the development of eating disorders. While these authors proposed theoretical conceptualisations on the psychological, familial and social factors that may be involved in developing anorexia, in particular the role of developmental processes, the role of family interaction and social experience, it is other researchers and academics who have sought to explore some of these hypotheses further. This has yielded mixed findings, some of which support some of the hypotheses and themes proposed by Bruch and Crisp and others that fundamentally oppose them. I will explore these next by moving to discuss some of the literature that takes forward some of Bruch and Crisp's central conceptualisations of anorexia. This literature is also largely situated within a medico-clinical epistemology.

Before doing so, it is important to add that in recent years, there has also been a growing interest in the area of brain research and various hypothesis are being explored which seek to establish whether the aetiology of anorexia is based on brain functioning. Research focused on neurobiological traits continues. A systematic review of the use of functional neuroimaging in anorexia explored the neural systems that would affect the visual system, attention network, the arousal and emotion processing systems, the reward processing network and the network for body schema (Pietrini et al, 2010). The hypothesis suggests that the activation of these neural systems has an impact on issues such as body image perception, the regulation of emotion and the capacity to engage in prolonged episodes of self-induced starvation.

The study of the biological components of anorexia includes understandings of the role of genes as well as personality and neurobiological traits. Collier and Treasure (2004) argued that anorexia has a complex multifactorial aetiology, involving the interaction of genes and the environment, particularly social factors. To date, genetic research

continues but has not yet developed to instruct new treatments. These authors stated, "Despite this progress, the study of gene-environment interaction has barely been touched to date" (page 365).

A recent systematic review concluded that hardly any of the positive findings in these studies were unequivocally confirmed or substantiated in meta-analysis (Scherag et al, 2010). Despite the inconclusive status of research in this area, the findings highlight the interest in understanding anorexia as a condition bound to the individual's biological processes and how these interact with his or her environment. These include the individual's interpersonal attachment processes and the role of adverse life experiences on the individual. These factors will now be explored further.

2.3(2) The role of attachment processes in the aetiology of anorexia

Bruch's work in particular was influenced by research and growing clinical interest in the area of infant attachment. Attachment theory is a psychological, evolutionary and ethological theory initially formulated by John Bowlby (1958), concerned with human relations and in particular the emotional bond between people. A fundamental concern of attachment theory relates to the essential nature of a primary attachment relationship between a young child and caregiver, most frequently but not exclusively a parent, to allow for social, emotional and physical development to occur. Attachment is a 'safety regulating system' to ensure the vulnerable child is suitably protected by an adult and is a feature of a relationship rather than a characteristic of the child. In other words, attachment is an interpersonal process. By the carer attending sensitively to the infant's needs, the child learns about the emotional and physical availability of the caring other. Bowlby postulated that, over time, patterns of attachment behaviour develop that are subsequently internalised by the child, creating an 'internal working model' for relationships.

Work by Mary Ainsworth in the 1960s and 1970s helped to create measures to further define and measure attachment, by researching separation between children and their caregivers in a laboratory setting, named the 'Strange Situation' (1978). Ratings were classified as Secure, Avoidant, Ambivalent (Ainsworth, 1979) and later a fourth category of Disorganised/Disorientated was added (Hesse, 1996; Main and Soloman, 1986).

There has been a growing interest in the possible relationship between attachment difficulties and eating disorders (O'Kearney, 1996; Ward et al, 2000). Some studies identify anxious attachment styles (Armstrong and Roth, 1989; Chassler 1997) and others, ambivalent/avoidant attachment styles (Friedberg and Lyddon, 1996; Salzman 1997; Ward et al, 2000 and 2001; Candelori and Ciocca, 1998) in the interpersonal relationships of people who develop anorexia.

These studies broadly look at the health and wellbeing of the primary carer, usually a mother, the impact of this on parenting practises, and the subsequent attachment patterns internalised by the child. For example, in a transgenerational study exploring attachment processes in anorexia, Ward et al (2001) examined the attachment status of people with severe anorexia nervosa and their mothers. They found significant psychiatric difficulties in over half of the group of mothers. They also found a significantly high incidence (67%) of unresolved loss and trauma among the mothers, compared to 19% in a meta-analysis of women without eating disorders (Ijzendoorn et al, 1996). While these results cannot be generalised to all sufferers of anorexia, this study highlights possible factors that may have affected the wellbeing of the mothers in this study who had to negotiate the process of attachment with their child, whilst suffering from unresolved trauma or loss, or affected by compromised mental health.

Ward and Gowers (2005) later went on to identify how mental ill-health in either parent presents particular difficulties for his or her relationship with the child. They argued that parents can transmit attitudes about self, others and the world. In the case of a depressed parent, this may impact emotional responsiveness, while with an anxious parent, this may impact on the child's basic feelings of security. Where an internal working model is comprised of high levels of vulnerability, this can lead to anxiety states and ultimately contribute to an anxious attachment style.

Swanson et al (2010) examined the relationship between parental bonding, social problem-solving and eating related difficulties, found that disordered eating was significantly correlated with low maternal care and high control. They argued this would result in a relationship where the mother would have a significant degree of influence over many aspects of the child's life but without a strong sense of warmth, acceptance

and valuing of the child. The authors reported that this contributed to difficulties in the attachment bond, particularly leading to an ambivalent/avoidant interpersonal process.

Another significant attachment relationship involves that between a child and his or her father. Although fewer in number, there are some studies that explored the relationship between paternal-child attachment processes and eating disorder development. For example, a case series study by Brinton et al (2005) explored the impact of parental personality on eating disorder development. They found specific associations between parental personality difficulty, namely in relation to fathers' levels of narcissism. The authors suggested that the father may be insufficiently attuned to the needs of his child given the predominant preoccupation with the self that is characteristic of narcissistic traits. This study corresponds with the findings of Steiger et al (1989), which found dramatic-erratic traits in fathers associated with daughters' eating concerns.

A further area of investigation is the attachment relationship between mothers with a history of an eating disorder and their children. Koubaa et al (2008) found that over 90% of mothers with a history of anorexia or bulimia nervosa reported problems with their maternal adjustment and parenting during the first three months after delivery. These mothers frequently reported being disappointed by motherhood, and/or failing to enjoy caring for their baby's needs. The implication from this study is that the quality of the attachment bond was affected by the mother's difficulty with maternal adjustment, which included the challenges of a new role and body image concerns post-pregnancy.

Despite the existence of studies that explore the role of attachment processes and familial interpersonal difficulties in the development of anorexia, there remains a robust debate regarding the role of family relationships in the aetiology of anorexia. For example, in a position paper written by the Academy of Eating Disorders, Le Grange et al (2010) consider the hypothesis of the role of the family in influencing the development of anorexia as similar to the way in which schizophrenia was previously viewed as a response to family dysfunction, described with the now discredited term the 'schizophrenogenic' family. They argued that the research findings were methodologically flawed. The authors accounted for the disturbance seen in families of sufferers of anorexia, as a *reaction to* the intense stress the illness places upon the family system, not a predisposing risk factor.

A clear divide exists in the literature, some arguing that family has a role in influencing the development of anorexia, while others argue they are not part of the problem, and should be viewed instead as part of the solution to support recovery.

2.3(3) The role of adverse life experiences in the aetiology of anorexia

Another dominant area of interest and research exploring medico-clinical aetiologies of anorexia is the role of adverse life experiences. There are a number of studies that hypothesis that difficult life experiences can be proximal precipitants to eating disorders.

Adverse life events can include incidents of a physical, sexual, emotional, interpersonally or practical nature. They may be discrete and represent a 'one off' event, or can be experienced repeatedly over time. Adverse life events can also represent the loss of something valued, such as a relationship with a loved one who dies. They can also involve an experience or experiences that are traumatic. I have found a range of studies that explores such experiences.

Brown and Harris (1978) explored the role of life events and difficulties in the onset of anorexia. They found that significantly more people diagnosed with anorexia than community controls had experienced a major difficulty in the year prior to the onset of anorexia (67%). The most common serious life events concerned close relationships with family, with more troubling events concerning a range of sexual issues (Schmidt et al, 1997).

Other studies have specifically focused on the role of sexually abusive experiences as a risk factor in developing eating disorders. Wonderlich et al (1997) concluded that childhood sexual abuse is a risk factor, particularly in developing bulimic symptomology. There have subsequently been two meta-analytic examinations of the relationship between childhood sexual abuse and eating disorders (Rind et at 1998; Smolak and Murnen, 2002). Both studies had small sample sizes, but found a small, significant relationship between the experience of childhood sexual abuse and eating disorder development.

Case series studies have continued including Rayworth et al's (2004) study, which found that women who reported childhood physical and sexual abuse were three times as likely to develop eating disorder symptoms as those who reported no abuse. Using case comparison between two groups who had responded well or unsatisfactorily to treatment, Rodriguez et al (2005) found that 45% of the patients with eating disorders had a history of sexual abuse or trauma, when collecting case data retrospectively. Similarly, Carter et al (2006) found that 48% of inpatients in a particular eating disorder unit reported a history of childhood sexual abuse.

A number of researchers have explored the possible mediating relationship between early trauma such as childhood sexual abuse and the increased risk of developing an eating disorder. Mediating variables such as shame, dissociation, impulse control, anxiety, substance use, cognitions and mood instability have been highlighted (Andrews, 1997; Kent and Waller, 2000; Murray and Waller, 2002; Wonderlich et al, 2001).

More recently, a link has been proposed between levels of depression and self-esteem in female survivors of sexual abuse, finding that participants were significantly more depressed and tended to have significantly lower self-esteem. It was found that this contributed to poorer outcomes in treatment given the higher levels of psychological ill-health (Harper et al, 2008).

However, some authors challenge the specific association between childhood sexual abuse and eating disorder development. For example, in a review of risk factors adopting the risk factors approach by Kraemer et al (1997), Jacobi et al (2004) argued that the experience of sexual abuse in childhood is a risk factor for a range of mental health difficulties. This position was also echoed in other studies, which argued that childhood sexual abuse leads to a range of different mental health difficulties (Kendall-Tackett et al, 1993), not exclusively anorexia. Crimes such as childhood sexual abuse and rape are notoriously under-reported and aiming to establish an accurate representation of the relationship between such traumatic experiences and eating disorder development poses significant challenges. Nonetheless, it adds weight to the importance of developing research methodologies which create an optimum environment for sufferers to discuss whether this has been a significant risk factor for them.

In addition, childhood emotional abuse, including physical and emotional neglect has also been considered a risk factor for eating disorder difficulties (Kent and Waller, 2000; Mazzeo and Espelage, 2002). Kent and Waller (2000) found that emotional abuse most clearly influences eating difficulties. Moreover, a further study using data from the 1970 British Cohort study which examined associations between suggested childhood risk factors and self-reported anorexia at age 30 years concluded that there were four risk factors, one of which is childhood emotional problems. The others were parenting, childhood BMI and academic ability or the centrality of exercise during childhood (Nicholls and Viner, 2009).

Another case control study of risk factors for anorexia concluded that family discord and higher parental demands were reported more frequently (alongside negative affectivity and perfectionism) and with a high degree of severity in woman with anorexia (Pike et al, 2008). These would presumably lead to a range of different stressors and life event challenges. These findings are consistent with Jacobi et al's (2004) review of risk factors in eating disorders concluding there is some evidence that sufferers of anorexia experience more stressful life events before the onset of their eating disorder than controls subjects.

These studies offer information about the potential difficulties a sufferer may be exposed to prior to the development of anorexia. They raise a significant possibility that anorexia may not 'develop out of nowhere', but instead be triggered by or arise out of other types of stressors and challenges in the individual's life. This has implications when considering how best to support sufferers who develop anorexia and what might be included within an effective helping intervention.

In *2.6.2*, I explore the literature on psychotherapies for anorexia and within it discuss an academically and clinically influential perspective, which suggests that treatment, including psychotherapy, should prioritise the alleviation of symptoms associated with anorexia, as opposed to engaging in subjective meaning-making about the function of anorexia in a sufferer's life. However, if treatment addresses only the most obvious signs of anorexia, namely weight and shape concerns and the use of strategies to ensure sustained weight loss, it potentially excludes the opportunity to address and support the sufferer with the difficulties that were significant at the time of the development of

anorexia, i.e. the difficulties that some studies postulate are risk factors for developing a serious eating disorder. I wonder if the failure to address such issues within treatment has a relationship with the poor outcomes for sufferers and the lengthy process of recovery mentioned in section *1.2.* This issue will be revisited later in this chapter. However, I will now review some of the dominant socio-cultural perspectives on developing anorexia.

2.3(4) Socio-cultural approaches to developing anorexia: Prominent contributions

The role of social processes in shaping the development of anorexia has also been given significant attention. As early as 1880, Fenwick hinted at their role when he described anorexia as principally a disorder of the upper class. This idea prevailed for many years. However, more recent survey studies and case reports suggest that anorexia affects a wide range of economic and geographic groups (Miller and Pumariega, 2001). The last twenty years have seen the emergence of numerous ideas about the social factors linked to the development of anorexia and the psychologically-driven conceptualisation of anorexia is reframed and resituated within a social context.

A prominent sociocultural theory proposed a relationship between body dissatisfaction and problematic eating and the oppressive patriarchal attitudes dominating contemporary society (Orbach, 1978, 1986, Chernin, 1981, 1985, Wolf, 1990, MacSween, 1993; Hepworth, 1999). These authors provide gendered understandings of the development and meaning of anorexia. They argued that the significant over-representation of girls and women who suffer from anorexia is not coincidental. For example, Orbach argued that the development of anorexia is inextricably linked to gender-specific discriminatory conditions for women. She suggested women's relationships with food, body size and shape, their views on 'fatness and thinness' and what it means to be feminine contains two fundamental imperatives. Firstly, throughout history the female body has been an object of pleasure for men. Examples span from paintings and photography to strip clubs and pornography. Secondly, a paradoxical relationship has developed between women, food and feeding. Women are typically socialised to feed others but restrain their own intake of food.

Other have written about the relationship between cultures in transition and how this might change the health profile of citizens, which may in turn provide indications of risk variables for developing certain illnesses (Susser and Watson, 1963) and specifically the development of anorexia (Katzman and Lee, 1997). These authors argued that eating disorders may be precipitated by societal difficulties with transition, dislocation and oppression and how such 'outside' social forces get 'inside' the individual, producing solutions in the control of weight, shape and eating. Lee (1995) suggested:

> anorexia develops in response to a complex orchestration of sociocultural elements including capitalism, urbanisation, immigration, food abundance, rising population weight norms, advanced information technology, proliferation of body-orientated advertisements, decreased birth rate, and change in social norms of women (page 3).

While Crisp's (1980) made reference to socio-cultural issues and specifically the way in which a young person must respond and adapt to the "available social matrix" (page 49), Lee's formulation illuminates that social matrix in more detail. Moreover, it raises the possibility that anorexia emerges not from specific geographical sites, economic groups or the female gender. Instead it is bound to the issue of *modernity*.

The rapid changes involved in the modernisation of cultures, is the social matrix most cultures now navigate. Ground-breaking studies such as Becker's examination of the impact of the arrival of television in Fiji (Becker et al, 2002; Becker, 2004) provided evidence of a dramatic increase in the indicators of disordered eating associated with mass media influence. On the one hand, this may relate to the ways in which the media is used to expose people to images of ultra thin models. It is argued that the internalisation of these images contribute directly to body image difficulties and subsequent eating problems (Stice et al, 1994; Heinberg and Thompson, 1995; Groesz et al, 2002). Indeed, further studies supported the notion that the media is used to generate and maintain modern Western beauty ideals (Thompson et al, 1999) as people are exposed to continuous reinforcing mechanisms of the ascetic ideal through the mass media, including television, internet, films and printed media (Derenne and Beresin, 2006). On the other hand, eating disorder difficulties may emerge from a more fundamental dilemma with identity based on exposure to multiple influences guiding the development of the self, not exclusively beauty ideals. For example, an epidemiological

study conducted in the Caribbean island of Curacao by Katsman et al (2004) found that the women who presented with anorexia presented with a "triple threat to identity formation" (page 465). The triple threat refers to three factors. Firstly, all participants were of mixed race and aspiring to fit with the socially and economically mobile elite. Secondly, all had the means for education and travel. Consequently, they were caught between the modern and traditional constructs of femininity. Finally, all had lived overseas and struggled upon re-entry with the more limited possibilities of island life. In other words, the participants in this study defined themselves as "not typical island women". They viewed themselves as a sub-group and anorexia was examined as an expression of their membership of a distinct subculture. What this study helpfully offers is an exploration of the ways in which such socio-cultural and psychological processes interact.

The relationship and interconnection between social and psychological processes is an area of growing interest. Socio-cultural models have developed to explore possible vulnerability factors and the psychological processes that may affect the extent to which such pressure affects women (Stice et al, 1994; Dittmar and Howard, 2004; Dittmar, 2005). For example, Harrison, (2000) explored the ways in which the media is a potent mechanism for the socialisation of young people and arguably works as a behaviour-reinforcing mechanism. In addition, Stice et al (1994) and Blowers et al (2003) argued that variables such as high levels of social comparison, low self-esteem and internalisation of a thin-ideal may render some people more vulnerable to developing eating difficulties. The application of social comparison theory (Festinger, 1954) in the study of eating disorders has continued as an area of research. Social comparison has been argued to relate to uncertainty about the self as well as a desire for self-reassurance (Eurich and Byrne, 2004). This theory would suggest that by frequently making comparisons with the images portrayed in the media, some individuals have increased vulnerability to socio-cultural appearance pressure Thompson et al, 1999; Cattarin et al, 2000; Tiggemann and McGill, 2004). Moreover, persistent appearance-related social comparison with models and attractive peers may increase vulnerability to weight-related anxiety and disordered eating (Cattarin et al, 2000; Groesz et al, 2002; Tiggeman and McGill, 2004; Engeln-Maddox; 2005, Grabe et al, 2008).

Bamford and Halliwell (2009) investigated social comparison theories of eating disorders in relation to attachment. A discussion of the attachment literature can be found in section *2.3(2)*. They reviewed attachment literature which proposes that people with high attachment anxiety are motivated to acquire close relationships and have a tendency to idealise others while devaluing themselves (Greenwood and Pietromonaco, 2004). They concluded that people who have a high degree of attachment anxiety are likely to view themselves unfavourably when compared with other people. Interestingly, this did not protect people who have a high degree of attachment avoidance. They are made vulnerable to eating disorder development because they tend to deactivate normal attachment responses, diverting attention away from distress-evoking stimuli or attachment-related thoughts and are more likely to engage in internally controlled ways of regulating emotion, such as dietary restriction (Schmidt and Treasure, 2006).

Reviewing these contributions in understandings of anorexia from a socio-cultural perspective, there is a striking absence in understandings of the development of anorexia in boys and men. Historically considered as a female condition, anorexia also effects boys and men (Langley, 2006). 5-10% of anorexia sufferers are reported to be male (Alexander-Mott et al, 1994) and gender has little effect on the features of anorexia, although the illness tends to run a more protracted course for females (Strober et al, 2006). Therefore, it appears that to be male and be a sufferer of anorexia is to be part of an even more hidden and potentially marginalised group of sufferers, whose needs and experiences may be overlooked by socio-cultural perspectives which understand anorexia predominately as a gendered problem.

2.3(5) Discussion on the academic debates on developing anorexia

This review of the literature has covered a broad range of debates, some of which point to areas of convergence, whilst others are philosophically and practically divided. Despite the historical influence of divergent perspectives on the aetiology of anorexia, broadly defined as medico-clinical or socio-cultural approaches, in recent times theories of anorexia are generally considered to be multifactorial, including the combination of and interaction between genetic and familial (Bulik et al, 2000), personality and psychological (Vitousek and Manke, 1994) and environmental and neurobiological factors (Key et al, 2006).

In summary, singular aetiological hypotheses are unable to sufficiently account for the complex and interacting factors involved in anorexia (Lask, 2000) and recent explanations have called for an integrative multi-disciplinary approach (Connan et al, 2003; Treasure et al, 2005; Schmidt & Treasure, 2006). Lask argued:

> eating disorders are multi-determined with a wide range of interacting factors. Genetic, biological, personality, psychological, familial and socio-cultural factors are all likely to be relevant (Lask, 2000, page 63).

Moreover, he argued that eating disorders do not occur at a particular moment, a 'big bang theory', but develop as a result of:

a) Predisposing factors - Factors that are necessary preconditions for the development of an eating disorder;
b) Precipitating factors - Factors that are more immediately connected with the emergence of the eating disorder, and
c) Perpetuating factors - Factors that serve to maintain the condition once it has arisen.

However, while theories of aetiology are generally considered to be multifactorial, the relative contribution of specific aetiological factors and the interactional relationships between them remains unknown. What makes aetiology important, and in particular the existence of multiple convergent and divergent aetiological perspectives, is that treatments are often based on a formulation of causal factors. It would appear that the plurality of aetiological perspectives has contributed to the development of a broad range of treatments. However, the lack of consensus on aetiology may contribute to Palmer's (2006) earlier critique of the status of treatments and reflects a mood of uncertainty about what causes anorexia and therefore what constitutes effective treatments. Alternatively, the diversity of treatments may also reflect the complexities of anorexia and the need to offer treatments across several domains, addressing the biological, physical, psychological, family interactional and social issues related to it.

Given the diversity, complexity and uncertainty in current understandings and perspectives on the aetiology of anorexia, it is imperative to include sufferers'

perspectives by hearing about the lived experience of developing anorexia. This can significantly assist to advance understandings in this contested and uncertain area. I will now discuss available literature that draws upon sufferers' perspectives on the development of anorexia.

2.4 Sufferers' perspectives on developing anorexia

Personal stories about developing anorexia occupy a prominent place within contemporary culture. This is portrayed in literature (for example, Hornbacher, 1999), magazines articles, which regularly have pictorial articles of people who have suffered from eating disorders (for example, "Kings of Leon Front Man Talks About Secret Anorexia Battle", Heat magazine, Dec 2008; "I'm Terrified my Kids Will Copy my Anorexia", Closer magazine, Jan 2010), on internet sites with the rise of both pro-anorexia and pro-recovery websites (for example, www.prettythin.com; www.somethingfishy.org), on television (for example, the Channel 4 series, Supersize versus Superskinny), in music videos (for example, the 2006 music video for 'Stupid Girl' by the American singer Pink. In it she enacts a scene of post-meal vomiting) and in films and documentaries (for example "Helen's Story" created by BBC Scotland in 2005 explores a young woman's experience of anorexia).

However, in reviewing available literature on developing anorexia, it is notable how scarce published research is from the sufferer's perspective. There are currently very few published articles, which specifically focus on sufferers' perspectives of developing anorexia. It is not entirely clear why this is the case but may relate to a number of issues.

While research into anorexia is limited across the board (Strober, 2005; Palmer, 2000), published literature in the field of eating disorders continues to be over-represented by quantitative studies. One possibility is that sharing our personal experiences, or put another way, storytelling, is so familiar to all of us, that it may be viewed as an unacceptable means of doing research. The rise of evidence-based medicine (EBM) has been founded on the aspiration to produce "a coherent and comprehensive approach to allow clinicians to base their practice on the best available evidence" (Geddes, 1998).

However, the approach to 'best evidence' developed by Bandolier (1994) and embedded in the National Service Framework (Department of Health, 1999) has created a hierarchy with meta-analysis of randomised control trials at the top and personal accounts at the bottom. The implication of this for research which explores sufferer perspectives is that it is not seen as 'good quality' research. Therefore less funding is available for studies of this type and there is less willingness and enthusiasm from researchers to engage in projects of a lower status. In other words, research which explores sufferers' perspectives on developing anorexia is *valued less.*

Another possibility relates to the way in which anorexia is described as egosyntonic (Vitousek et al, 1998) or "maddeningly egosyntonic" (Strober, 2004). Egosyntonicity has been described as a phenomenon in which the individual experiences anorexia as "being a part of themselves or their identity" (Tan et al, 2003, page 537). There is a danger that the contribution of people who have personal experience of anorexia should be treated with caution or suspicion. This could lead to creating a 'them and us' divide between the people who experience anorexia and those who aim to treat it. Such a divide will maintain uncertainty or even mistrust on the part of clinicians and researchers who may not believe that an individual's subjective views on the development of their illness will be helpful; that it may be skewed by the presence of perceived advantages of anorexia. In other words, research which examines sufferers' perspectives on developing anorexia is *trusted less.*

There are a few exceptions and I shall now discuss a small number of studies which explore subjective views of developing anorexia.

A qualitative study by Tozzi et al (2003) explored sufferers' subjective accounts of the causes of anorexia and the factors that fostered recovery. Participants were asked to share their views on the causes of their eating disorder. Findings revealed the most commonly mentioned perceived causes were dysfunctional family relationships, the role of weight loss and dieting, and stressful experiences and perceived pressures. These findings are intriguing as they appear to support some of the findings that have been reviewed earlier, namely that anorexia develops in a socio-cultural context where weight and shape are viewed as important aspects of self-evaluation, where the pressures of daily life are managed by the deployment of weight loss strategies and where

dysfunctional family relationships are seen as a proximal precipitant for eating disorder development.

Holliday et al (2005) developed a qualitative study which explored the illness beliefs of people with anorexia. This study draws upon the health belief literature within physical health, adopting the self-regulation model (SRM; Leventhal et al, 1984). This model proposes that individuals create implicit internal models about their illness which help them to make sense of their experiences and influence their coping behaviours. The SRM offers five key dimensions of illness representation: causes, consequences, identity, timeline, and cure/controllability. Adopting this to explore beliefs about anorexia, the study found that participants perceived anorexia as a chronic condition, as having strong negative consequences, low controllability and curability, being difficult to understand and as having a high number of symptoms. They also found that participants reported a high number of physical symptoms and concluded that this was evidence that participants held a strong illness identity.

However, in another qualitative study exploring illness perceptions in anorexia, Higbed and Fox (2010) offered a critique of the Holliday et al study. They argued that the method, which draws upon health beliefs from the physical health literature, may not be directly applicable to perceptions of mental health difficulties. Higbed and Fox supported the views of Kinderman et al (2006) who argued that some of the underlying assumptions from the SRM are not directly applicable to mental health, including the complication that beliefs about mental health are not static and are liable to alter in a more dynamic way. In addition, people with mental health problems may not strive to hold such coherent beliefs or even possess an 'illness model'. Furthermore, an individual may not be able to distinguish between the 'self' and the 'illness', as the capacity to experience a coherent sense of self can be impacted by the mental health difficulty (Bentall, 2003; Myers and Brewin, 1996).

In their study, Higbed and Fox (2010) employed a constructivist grounded theory methodology (Charmaz, 2006) and developed an interpretative theory of illness in anorexia comprising four related categories: 'making sense of anorexia', 'the relationship between anorexia and the self', 'the recovery struggle', and 'coping with treatment'. Under 'making sense of anorexia', participants discussed their views of what

anorexia is and whether they perceive it to be an illness or not. They also discussed ideas about causes, that anorexia is meaningful but can equally be unexplainable and difficult to understand. Under 'the relationship between anorexia and the self' participants explored the complex issue of anorexia and personal identity. Some used externalisation techniques to describe anorexia as something separate from the self, whereas other participants identified it as part of the self. Some talked about losing the self to anorexia and their impairment of judgement and insight. Under 'the recovery struggle', anorexia was frequently described as something that is difficult to give up, and some articulated pessimism about the future when reflecting on anorexia as an enduring experience. The analogy of recovery as a 'battle' was commonly used. Under 'coping with treatment', this was frequently narrated as a stressful experience, although it could equally be experienced as protective and beneficial.

This study highlights the value of understanding personal representations of anorexia, which offers useful points for reflection on therapeutic work. For example, the authors concluded that participants' relationship with anorexia was described on a continuum which started from total possession by anorexia to being viewed as separate and external. However, this is a dynamic process and can involve moving along the continuum. This dualism, which can occur even for the same individual, has implications for therapeutic work in terms of reflecting upon the patient/client's current position on the continuum, the types of interventions that are better suited to the individual at the time and the quality of therapeutic relationship required. For example, a factor said to drive the behaviours of people with anorexia is the inner voice some sufferers recount hearing. An example of such an inner voice was offered at the beginning of Chapter One.

In a thematic analysis of the 'anorexic voice', Tierney and Fox (2010) argued that the bond between the individual and their anorexic voice could explain ambivalence to change. They suggested that therapists must persist in their endeavours to penetrate this tie, whilst acknowledging the hold of it. I would argue that if anorexia is subjectively experienced as a part of the self, not an externally imposed occurrence (that one might experience when developing other kinds of illness), or the sufferer holds personally meaningful views about the perceived value or helpfulness of anorexia, then this is all the more reason to hear from sufferers and aim to understand that position further. Furthermore, this has profound implications for treatment and the notion of recovery,

particularly if recovery is subjectively experienced as a process that will require 'giving up' or somehow 'losing' a part of the self, and where treatment entails interventions that facilitate such a potentially aversive process. Exploring the illness experiences of sufferers of anorexia can provide key insights into beliefs, attitudes, behaviours and barriers or conduits to change.

In summary, there are a very limited number of studies that seek to explore subjective accounts and understandings of developing anorexia. These studies include an examination of perceived causes of anorexia (Tozzi et al, 2003; Higbed and Fox, 2010), illness beliefs associated with anorexia (Holliday et al, 2005; Higbed and Fox, 2010) and sufferers' intrapersonal relationships with anorexia (Tierney and Fox, 2010). While these studies offer valuable examples of subjective understandings of developing and living with anorexia, they raise important questions about whether these personally-held understandings and beliefs need to be addressed as part of the recovery process. For example, by therapeutic intervention that focuses on personal meaning-making. The Tozzi et al, (2003) study examined subjective accounts of developing anorexia and recovery, but did not explore the relationship between subjective understandings of illness development and subsequent recovery. This is an unexplored area that could usefully be examined within this study. I will return to this later in the chapter.

2.5 Defining Recovery: What is recovery from anorexia?

The term recovery is defined in the *Oxford English Dictionary* (Volume 3, 1997) as a "return to a normal state of health, mind or strength". The definition assumes the existence of a primary state, a "normal state" that the sufferer aims to return to during recovery. Exploring recovery from anorexia is a complex endeavour. It includes defining what might constitute recovery or the signs of a return to the previous state of normality.

There are significant difficulties with conceptualisation and measurement of recovery. Historically, recovery focused on physical criteria, such as weight restoration and menses (Morgan and Russell, 1975), with later additions of behavioural indices such as the absence of binge-eating, compensatory behaviours and dietary restriction (Bulik et

al, 2000; Field et al, 1997; Matsunaga et al, 2000; Strober et al, 1997). This developed further to include psychological factors, including body image concerns and fear of weight gain (Bachner-Melman et al, 2006; Couturier and Lock, 2006; Strober et al, 1997). However, a study by Couturier and Lock (2006) concluded that recovery rates varied from 3% - 96% depending on the method employed. This depended on whether recovery measures physical, psychological or social functioning, or a combination of the three. Windauer et al (1993) cautioned that figures representing a 'good outcome' may be exaggerated if the literature focused only on weight and menstrual status. Indeed Deter and Herzog (1994) reported that the inclusion of both somatic and psychological functioning measures in criteria for recovery lowered the rates from 54% to 41% when compared to physical criteria alone. Saccomani et al (1998) produced similar findings. When they added psychological criteria to somatic criteria there was a reduction in recovery rates from 79% to 49%.

Some authors question the value in setting a high threshold for recovery. For example, Herzog et al (1993) found that participants in their study continued to have symptoms of anorexia but also evidenced a high level of social functioning. This led them to question whether "studies requiring a symptom-free state for recovery may present an overly pessimistic view of these disorders by not permitting the observation of less dramatic improvements in the course of the disorder" (Herzog et al, 1993, page 842). Conversely, Bardone-Cone et al (2010) argued that a failure to assess for a fuller range of changes, including psychological changes may lead to a 'pseudo-recovery', where physical and behavioural changes are apparent but eating disordered cognitions and associated emotions persist. This is a significant issue as enduring cognitive and affect difficulties are argued to be predictive of relapse (Carter et al, 2004; Channon and DeSilva, 1985; Federici and Kaplan, 2008).

These studies reflect some of the methodological complexities in conceptualising and measuring recovery. Moreover, the lack of unanimity in defining what criteria should be used to describe what recovery actually is hinders attempts to draw meaningful generalisations from such studies (Herzog et al 1993; Pike, 1998; Jarmen and Walsh, 1999; Tozzi et al, 2003; Noordenbos and Seubring, 2006). The constraints on measurements of recovery may link to Russell's diagnostic criteria and to more fundamental challenges associated with diagnostic systems in psychiatry. Based on the

diagnostic criteria established for anorexia in 1970, it is logical that recovery could be conceptualised as a reversal and absence of these symptoms. However, some authors critique the limited descriptions offered in diagnostic classifications (for example, Fairburn's 2009).

More generally, Palmer (2003) acknowledged the utility of diagnostic classifications for researchers and clinicians but highlighted the limitations, which include trying to locate the complexities of human thought, feelings and behaviour into a fixed diagnostic label. Other authors fundamentally challenge diagnosis in psychiatry. For example, Hepworth (1994) argued that in the field of psychiatry, the existence of illness is "not so easily observable" (page 183). Similarly Lawrence (1994) and Hornbacher (1999) described their subjective experiences of diagnosis as dehumanising and invalidating.

2.5(1) Defining recovery: How do we talk about recovery?

A further challenge in conceptualising and measuring recovery relates to significant difficulties with the use of language in the eating disorders literature. This includes the way the terms 'recovery' and 'outcome' are used interchangeably (Strober et al, 1997; Finfgeld, 2002; Lowe et al, 2001; Couturier and Lock, 2006). The term 'recovery' is defined at the beginning of section *2.4*. The term 'outcome' is defined in the *Oxford English Dictionary* (Volume 3, 1997) as "the way a thing turns out, a consequence". The definition of 'recovery' assumes a return to a previous state (the "normal state" of health and wellbeing), whereas the definition of 'outcome' is neither as optimistic nor as specific. It refers to a consequence in general, which may or may not include a return to the previous state. In other words, outcome and recovery is not necessarily the same thing. For example, in a review of 108 anorexia outcome studies, it was reported that 45% of individuals recovered, 33% showed some improvement and approximately 20% continued to live with anorexia as an enduring condition (Steinhausen, 1999). A further review by the same author (Steinhausen 2002) argued that anorexia has not lost this relatively poor prognosis.

There are a range of studies that explore the factors that affect sufferer outcomes. Based on long-term research, several variables have been identified as significant in predicting course and outcome. Such variables include:

1. Vomiting: Individuals who present with vomiting as a core feature of their anorexia nervosa (subtype II) have a poorer prognosis compared to individuals with restricting anorexia (Da Costa and Halmi, 1992; Garner et al, 1993; Gowers et al, 2004; Touyz and Beaumont, 1984).
2. Weight at time of referral: Although low body weight has not always been demonstrated to be a predictor of poor outcome (Steinhausen et al, 1991), some studies indicate that low body weight is a reliable predictor of poor outcome (Hebebrand et al, 2004; Hsu et al, 1979; Gowers et al, 1994; Steinhausen and Seidel, 1993; Herzog et al, 1993). This may relate to genetic, social, nutritional, behavioural and metabolic factors or the interaction between such factors.
3. Duration of illness: Longer duration of eating problems before presentation for treatment is associated with poorer outcome (Herzog et al, 1992; Jones et al, 1993). Follow-up studies indicate that of those people who do recover, the vast majority do within 12 years (Hsu, 1988).
4. Age of onset: There is an association between later age of onset and negative outcome. Herzog et al (1992) found late onset to be the second most frequent predictor of negative outcome, and Steinhausen et al (1991) found it to be the most frequent negative predictor.
5. Attitudes regarding weight and shape: A significant percentage of individuals who achieve weight restoration do so *despite* their attitudes about their bodies. Channon and DeSilva (1985) found elevated scores in terms of anorexia-supporting attitudes and low desired weight at the point of discharge from hospital as predictive of relapse in the year follow-up.
6. Comorbidity: Anxiety disorders and depression are among the most common mental health difficulties associated with anorexia nervosa. Schork et al (1994) found that co-existing general mental ill-health was significantly associated with continuing eating disorder difficulties, and conversely, those who had recovered from their eating disorder reported no general mental health problems.

Although these studies are useful in highlighting the factors that may affect outcomes, they did not identify the relative importance of each of these variables (Jarman and Walsh, 1999), nor did they define the factors that contributed towards recovery.

The focus on sufferer outcomes lends itself to an examination of treatment. Treatments are generally linked to outcome, exploring "the way things turn out" as a consequence of treatment. If an individual has recovered and received treatment, it may be assumed that the recovery is a consequence of treatment. If an individual has received treatment, but failed to recover, it can be assumed that the treatment was ineffective, or that the sufferer was not ready to recover. However, if an individual has recovered but has not received treatment, this points to a conceptualisation of recovery that might include a broader range of factors, not those exclusively related to treatment. Indeed, Jarman and Walsh (1999) identified two important caveats in the outcome literature: the absence of clients' views on their recovery from outcome evaluation and the dissociation of outcome research from negotiated interpersonal and organisational meanings of recovery. They advocated for the development of methods and measures that can accommodate the diversity of sufferers' experiences of recovery, while remaining informative to researchers and clinicians.

2.5(2) Sufferers' accounts of recovery: What might recovery feel like?

Stories based on recovery from mental health difficulties have been increasingly reported in professional and academic journals (Barker and Strong, 2001; Jacobson, 2001; Lapsley et al, 2002; Leibrich et al, 1999; Ridgway, 2001; Thornhill et al, 2004) with more local contributions from the Scottish Recovery Network (Brown and Kandirikirira, 2006), part of the Scottish Executive's National Programme for Improving Mental Health and Well-Being (2003).

Having heard about the significant difficulties that researchers and clinicians have with defining recovery, other authors, such as Allot and Loganathan (2002) and Hatfield and Lefley (1993) have suggested that definitions of recovery will inevitably differ for individual sufferers of mental health difficulties based on their personal value system shaped through life experience. A pluralist position on recovery views it as a highly subjective and personally meaningful process (Anthony, 2007; Deegan, 1988). The criteria people use to measure their progress is difficult to quantify or compare. Moreover, while some qualitative studies into other types of mental health difficulty such as schizophrenia, mood disorders, and anxiety disorders illuminate the ways in which mental illness can undermine or fragment the individual's sense of self, anorexia

can be perceived as helpful or advantageous for some sufferers, and this has implications for the process of recovery, whether it is desirable and what the experience feels like.

Despite the numerous studies exploring recovery from anorexia from academic and clinical perspectives, there are still relatively few studies that explore recovery from a sufferer's perspective and even fewer that are published. As Darcy et al (2010) suggest, "There remains a wide gap in our knowledge about how individuals with anorexia themselves would operationalise recovery" (page 261), with few studies that recruit to consult former patients (De la Rie et al, 2006). However, there are more studies exploring recovery from sufferers' perspectives than there are on developing anorexia, perhaps because there is increasing recognition that people who have 'been there' may offer valuable insights we can all learn from.

2.5(3) Studies on sufferers' perspectives on recovery

A review of published research into sufferers' personal accounts of recovery from anorexia reveals a range of factors as aiding participants' recovery process. These studies include: Beresin et al, 1989; Hsu et al, 1992; Pettersen and Rosenvinge, 2002; Tozzi et al, 2003; Woods, 2004; D'Abundo and Chally, 2004; Weaver et al, 2005; Lamoureux and Bottorff, 2005; Keshi-Rahkonen et al, 2005; Nilsson, 2006; Federici and Kaplan, 2008. Given my particular interest in sufferers' perspectives on recovery from anorexia, I intend to explore these studies in detail. I will discuss each of the studies before moving on to discuss what this body of work contributes to current knowledge in the field of anorexia, as well as elucidating important areas that have not yet been explored.

Beresin and colleagues (1989) followed up thirteen women who had recovered from anorexia. Using structured interviews, they explored what helped participants to recover. They found that the process of recovery involved both therapy and non-therapy factors. Therapy factors included forming a therapeutic relationship which enabled the sufferer to identify and express their feelings, experience empathy and understanding from their therapist and explore how to separate and individuate from their family of origin. Non-therapy factors included the pursuit of positive life events such as embarking on educational programmes, getting a stable job, having a partner and child,

or the hope of eventually having a child. They argued that a central task is to support the sufferer to develop a more cohesive self-identity, which is less reliant on unhelpful family relationships or the eating disorder.

Hsu et al (1992) followed up six recovered women 20 years after the onset of their illness and discussed each of their individual experiences of recovery. During unstructured interviews, self-reports of recovery were created and the narrative account of each woman discussed. Recovery included a diverse range of factors from psychotherapy, increased motivation to change, interpersonal relationships, and adverse inpatient experiences. The authors concluded that "personality strength", "self-confidence", "being ready" and "being understood" were the factors most commonly identified as important for the participants. Whilst acknowledging how each of these descriptions may carry different meanings for different sufferers, they argued that this should not prevent us from "operationally" defining them and then studying them in treatment trials. It does not appear that this has been taken forward in such specific terms.

The study by Pettersen and Rosenvinge (2002) involved forty-eight patients' perspectives on both improvement and recovery from eating disorders. The aim was to describe the factors identified by sufferers of eating disorders as contributing to their recovery, examine how sufferers define recovery and relate their subjective experiences with measures of eating disorder symptoms, personal health control, and a clinical consensus-based list of items potentially relevant to recovery from eating disorders. Participants were asked what factors were helpful to them in the recovery process (question 1), and what was the meaning of recovery (question 2). In response to question (1), there were 7 responses:

1. To accept myself and my body (76%)
2. Not to use food to resolve problems and not to let food dominant life (76%)
3. To feel that life has a purpose to oneself and others (38%)
4. To have contact with emotions and the courage to express them (33%)
5. To have less anxiety and depression (29%)
6. To fulfil own potential and not just conform to expectations from others (20%)
7. To have good social functioning (13%).

In response to question (2), all participants reported that admitting their eating disorder was the first step in the recovery process that took many years. The general pursuit of recovery was the desire for a better life. The overriding motives to recover were to prevent the eating disorder from dominating life, to evade negative medical, social or professional consequences of the eating disorder, or because they were "fed up" having an eating disorder. Three more specific aspects of recovery were also identified. Firstly, the effect of professional treatment: treatment effects were related to a feeling of "being ready" and "motivated to change". Therefore a positive treatment experience was related to timing and being ready to change. Secondly, the effects of non-professional care were identified. These included meeting other sufferers. Thirdly, the effects of positive life events and important persons were highlighted. This aspect involved the emotional and practical support provided by close friends, a partner or parents. Positive life events included continuing education or getting a stable job. The three most commonly cited factors contributing to recovery were supportive non-familial relationships, therapy, and maturation. Participants said that a supportive relationship was the driving force that assisted them in recovery.

Tozzi et al (2003) explored subjective views of developing anorexia and recovery. Themes of motivation and both professional and non-professional helping relationships were identified as important for recovery. Using interviews and self-report questionnaires with sixty-nine women, the authors found that recovery from anorexia involved a range of different issues, including "waking up" to the implications of anorexia, maturation, supportive intimate relationships, supportive friendships, help from other patients, leaving home, religion, having children or becoming pregnant, increased self-esteem, willpower, a "good loss" such as ending a problematic relationship and employment. Professional help included the use of medication and psychotherapy. Psychotherapy was described as "good" when it involved being listened too.

Interestingly, a study has been undertaken exploring the recovery experiences of eighteen young people who did not receive treatment (Woods, 2004). In this study, Woods found that recovery was initiated through empathic, participatory efforts of parents and friends or recovery was self-initiated. Early parental intervention was cited as the most important aspect for those who had the shortest duration of anorexia.

D'Abundo and Chally (2004) interviewed twenty female participants with a history of anorexia in individual interviews and a focus group. Using grounded theory, they devised an explanatory scheme about recovery based on participants' responses. The most important factors to help reach a stage of recovery was acceptance of anorexia as an illness, spirituality and relationships, or the interaction of these all which contributed to the individual's feelings of self-worth.

Adopting a similar method, Weaver et al (2005) studied twelve women who had recovered from anorexia. Using interviews, the authors concluded that "finding me" was regarded as a turning point. "Finding me" was characterised as a shift in perception and perspective. This involved no longer perceiving anorexia as something that helped the participant attain life goals and aspirations. Those who took part also described movement from being a "victim" to an "active participant" during the recovery process.

Lamoureux and Bottorff (2005) also explored the process of recovery employing a grounded theory methodology. Conducting open-ended interviews with nine women who had recovered, the authors found that recovery focused on rediscovery and redefinition of the self. This included the following;

1. Seeing the dangers: This involved a developing awareness of the inherent dangers of anorexia, including risks to physical health and ultimately of dying.
2. Inching out of anorexia: This involved a slow and tentative process as participants began to take small steps of forming an identity separate from anorexia. This was made difficult by the perceived sense of control and power anorexia offers, the link with personal identity and core beliefs of 'not being good enough'.
3. Tolerating exposure without anorexia: This involved a process of letting go of the perceived security of anorexia and learning to tolerate the heightened sense of vulnerability. This included feelings of insecurity, powerlessness and identity confusion.
4. Gaining perspective by changing the anorexia mind-set: This involved a process of being to observe and challenge the misperception that food would make participants fat, that gaining weight meant becoming obese, and that being

heavier affected their value and worth as a person. Several strategies were employed including undoing 'wrong thinking', changing focus and creating distance. Undoing 'wrong thinking' required an increased awareness of and capacity to deconstruct unhelpful ideas. Changing focus required transferring attention from the body onto other areas of life, especially things that the participant found personally meaningful. Creating distance involved a transfer of focus from the self to other people and events outside of the self.

5. Discovering and reclaiming the self as "good enough": This involved an awareness of the extent to which participants viewed themselves as defective in some way and how recovery required the capacity to reclaim the self and be accepting of the self. This process included seeing the value other people could see in them, seeing value in themselves and accepting themselves as they are.

In an internet-based study exploring what thirty-five eating disorder sufferers suggest when they mention the word 'recovery', Keshi-Rahkonen et al, (2005) analysed messages posted on an eating disorders discussion forum. The contexts of the word recovery were analysed. The authors found that participants' views of recovery changed according to their current motivational stage. The value of professional interventions was also viewed as conditional upon the sufferer's readiness to change with professional interventions regarded as more helpful when the sufferer was feeling more ready and able to make changes. In addition, willpower and ceasing to identify with the eating disorder were seen as essential to recovery.

In a study exploring recovery in adolescent onset anorexia, (Nilsson et al, 2006) a qualitative approach was employed using individual interviews with sixty-eight women, some sixteen years after they had presented for treatment. Responses were coded using content analysis. The most valuable and important factors for recovery included the support of friends (43%), seeing oneself to be an active agent, including changing thoughts, increased willpower, insight, maturation, new decisions, persistence, and changes in their thinking of their own wellbeing instead of focussing on other people's needs (40%), activities, including work, a pet, travelling, reading books, dancing, music, writing, sports and art activities (33%), treatment (31%), family of origin (17%) and boyfriend, husband, own children (12%). As well as these positive turning points

towards recovery, participants also reported more challenging turning points, frequently associated with the risk of death or further physical harm.

More recently, Federici and Kaplan (2008) interviewed fifteen people who had and had not maintained a healthy weight about the factors that led to this. This study aimed to explore how individuals with anorexia engage with treatment and define recovery. Themes that differentiated both groups included motivation (internal vs. ambivalent), treatment factors (satisfaction with discharge planning vs. dissatisfaction with treatment), social support (being supported vs. isolation) and affect difficulties (awareness and tolerance of negative emotion and self-validation vs. self-criticism). Participants continued to experience eating disorder difficulties. Results were interpreted in the context of self-determination theory of motivation and suggested that patients should be involved collaboratively in the formulation of shared goals and concepts of recovery in treatment settings. The findings from this study support previous studies that highlighted how poor motivation contributes to decreased readiness to engage with treatment. Significantly, the more commonly cited reason for dropping out of treatment or the desire to do so involve a therapeutic rupture with a specific therapist. This supports the findings of another study which implicated patient-therapist factors are important in dropout from treatment (Clinton, 1996). In addition, although the majority of participants incorporated at least one symptom-focused factor in their conception of recovery, more than one third identified factors unique to each individual. This has implications for the therapeutic process and suggests that individuals may be more motivated to engage in treatment by being engaged in a discussion around aims that are personally meaningful and tangible to them.

In summary, there is a small collection of qualitative research studies which seek to explore and understand how people who have suffered from anorexia would define and operationalise recovery. Table 2 summaries some of the methodological characteristics of the studies, their research aims and findings.

Table 2: Studies that explore recovery from sufferers' perspectives

Author/ Year	Country	Participants	Method of data collection	Aim of study	Findings of study
Beresin et al (1989)	USA	13 female (age 18 and above)	Interviews	Explore what helps people to recover	Professional help (therapy/therapeutic relationship). Non-professional help (relationships and positive life events).
Hsu et al (1992)	UK	6 female (aged 17-44)	Interviews	Explore experiences of recovery	Motivation. Professional help (psychotherapy). Non-professional help (relationships).
Pettersen and Rosenvinge (2002)	USA	48 female (age 18 and over)	Interviews	Define recovery. Identify recovery factors. Review ED symptoms.	Motivation. Professional help (at the right time). Non-professional help (positive life events and relationships).
Tozzi et al (2003)	New Zealand	69 female (average age 32)	Interviews	Identify views on developing anorexia and recovery	Acceptance of anorexia as a difficulty. Professional help (psychotherapy and medication). Non-professional help (relationships, making important life changes / positive life events).

Woods et al (2007)	USA	18 -16 female / 2 male (aged 18-21)	Email Interviews	Explore recovery in young people who have not had treatment	Non-professional help (early intervention by parents, support from family and friends.)
D'Abundo and Chally (2004)	USA	20 female (age 18 and above)	Interviews / Focus group	Explore scheme of recovery	Acceptance of anorexia as a difficulty. Non-professional help (relationships / spirituality)
Weaver et al (2005)	Canada	12 female (age 18 and above)	Interviews	Explore what helps people to recover	Acceptance of anorexia as a difficulty. Motivation.
Lamourex and Bottorff (2005)	Canada	9 female (age 19-48)	Interviews	Explore the process of recovery	Motivation.
Keshi-Rahkonen et al (2005)	USA	35 (33 female / 2 male) (age 13 to 52)	Internet messages	Explore associations with the term 'recovery'	Acceptance of anorexia as a difficulty. Motivation Professional help (offered at the right time).
Nilsson et al (2006)	Sweden	68 females (age 30 and above)	Interviews	Retrospective exploration of recovery	Motivation. Non-professional help (friends, positive life events, relationships).
Federici and Kaplan (2008)	Canada	15 females (age 18 and above)	Interviews	Define recovery. Engagement in treatment	Motivation. Professional help (discharge planning) Non-professional help (social support).

Samples from the 11 studies included subjects (313 female participants, 4 male participants), aged 13 to 63. Most of the studies (9 of 11) included participants over the age of 18 years. Studies were conducted in the following countries: 1 in the United Kingdom, 5 in the United States, 3 in Canada, 1 in New Zealand and 1 in Sweden. These studies do not provide information regarding the age of onset of anorexia, the duration of illness, detail about treatment provision, including an in-depth explanation about psychotherapy as a treatment intervention.

Although these studies use different research methodologies (9 used face-to-face interviews; 1 used email interviews and 1 internet messages), reviewed as a collective body of work, there are a number of shared themes which exist across them. These themes address the way sufferers define recovery, the factors that are supportive to recovery and the way participants describe the process of recovery. I have called them: Accepting anorexia as a difficulty; Readiness to change; Professional support and Non-professional support.

Accepting anorexia as a difficulty: This involves redefining anorexia as life-limiting as opposed to life-enhancing. This insight is articulated in different ways in each of the studies, such as, "admitting it" (Pettersen and Rosenvinge, 2002), "waking up" (Tozzi et al, 2003) "acceptance of illness" (D'Abundo and Chally, 2004) or "seeing the dangers" (Lamoureux and Bottoroff, 2005). Acknowledging the existence and negative consequences of anorexia is presented as an important precursor to the sufferer's wish to change.

Readiness to change: This involves the premise that recovery can only take place when the sufferer is sufficiently motivated to change. Motivation can be influenced by a range of factors that create turning points in the sufferer's subjective experience of anorexia. For example, there are a number of positive factors that assist the sufferer to leave anorexia behind, as well as creating distance from unhelpful factors. Sufferers reported that initiating and maintaining supportive relationships (Beresin et al, 1989; Hsu et al, 1992; Pettersen and Rosenvinge, 2002; Tozzi et al, 2003; D'Abundo and Chally, 2004; Nilsson et al, 2006; Woods et al, 2007; Federici and Kaplan, 2008), and/or removing oneself from destructive and negative home environments served to facilitate adaptive change (Beresin et al, 1989; Hsu et al, 1992). Willpower, personal strength, the desire

for a better life and psychological readiness have also been identified as salient factors in eliciting and maintaining change (Hsu et al,1992; Keski-Rahkonen et al, 2005; Pettersen and Rosenvinge, 2002).

Professional support: There are two important factors associated with professional help. The first relates to the timing of intervention. In other words, professional interventions, such as psychotherapy are perceived to be helpful when made available at the point when the sufferer is ready to begin taking steps towards recovery. The second relates to particular aspects of treatment such as the quality of the therapeutic relationship, being understood by the therapist, being listened to by the therapist and being helped to express and manage emotions (Beresin et al, 1989; Hsu et al, 1992; Tozzi et al, 2003).

Non-professional support: These supports link directly to the positive factors that assist the sufferer to leave anorexia behind. They include meeting other sufferers, attending self-help groups, using internet chat rooms, meetings and courses, and meeting women who have recovered (Pettersen and Rosenvinge, 2002; Tozzi et al, 2003). Relationships with friends, colleagues and partners were mentioned (Nilsson et al 2006; Federici and Kaplan, 2008). Positive life events such as embarking on educational programmes, getting a stable job, having a partner and child, or the hope of eventually having a child are also identified (Beresin et al, 1982; Hsu et al, 1992; Tozzi et al, 2003). These non-professional supports illuminate the things that help people leave anorexia behind.

These studies offer interesting points of convergence in the shared themes of accepting anorexia as a difficulty, increased readiness to change and the role of both professional and non-professional support in promoting recovery. These studies span a range of factors that support recovery. These include factors relating to treatment experiences as well as those within the sufferers' interpersonal and environmental contexts.

However, an exploration of these studies raises a number of questions. Firstly, the only study which seeks to explore subjective accounts of developing anorexia as well as subjective accounts of recovery is the study by Tozzi et al (2003). The limitation of the other studies is that they fail to explore subjective experiences of recovery within a broader subjective context of what anorexia means or how it was experienced by the sufferer. In other words, these accounts of recovery are somewhat divorced from

sufferers' personal representations of illness. As a result, I am interested to better understand how sufferer's accounts of recovery relate to their accounts of becoming unwell and whether there are any meaningful connections between the two.

Secondly, some of the studies specifically mention particular psychological changes that influence readiness to change, such as willpower, personal strength, increased self-acceptance and self esteem, improved capacity to tolerate and regulate emotions, increased ability to challenge negative thinking and cultivating a new self-identity which is separate from their identity as an anorexia-sufferer. What is unclear is *how* the sufferer achieves these psychological changes. While a range of professional and non-professional help are identified as key themes across these studies, it is ambiguous if the changes that occur in recovery happen as a result of professional help, non-professional support or through a combination and interaction of both. As a result, I question what the role of professional and non-professional support is in contributing to the psychological changes that are essential to recovery. In addition, I am intrigued to better understand what the relative contribution of professional and non-professional support is in the recovery process and how one might inform the other.

Thirdly, although treatment and particularly psychotherapy is mentioned as important in some of these studies (Beresin et al, 1989; Hsu et al, 1992; Tozzi et al, 2003), they do not focus in detail on the factors that make psychotherapy therapeutic. While the role of the therapeutic relationship is mentioned, it is unclear if the provision of a therapeutic alliance is both necessary and sufficient to promote change and recovery or if more specific types of psychotherapeutic interventions are required. As a result, I continue to question what it is precisely that makes psychotherapy helpful for sufferers of anorexia and how it works in practice.

This review of available literature on sufferers' perspectives on recovery from anorexia has identified a number of important areas that have not yet been explored. These include:

1. Subjective accounts of recovery in relation to personal representations of developing anorexia in order to highlight potential meanings and understandings about the relationship between the two;

2. Subjective accounts and understandings of the psychological changes that support the recovery process. In particular, the role of professional and non-professional help in supporting the recovery process and the relative contribution of each, and
3. Particular factors that make psychotherapy helpful, including both technical and non-technical aspects of psychotherapy, such as particular psychotherapeutic interventions and the role of the therapeutic relationship.

These unexplored areas have implications for the focus of this study and will be discussed further in *2.8*. However, I will now move to explore available literature on the role of psychotherapy in recovery from anorexia.

2.6 The role of psychotherapy in recovery from anorexia

While there is consensus that the main aims of treatment for anorexia should include weight restoration and psychological treatment, *how* these goals are reached differs significantly across various theoretical positions and within clinical practise. Existing guidelines from NICE (2004) on eating disorders identify psychological intervention as a core aspect of treatment. The options of cognitive analytic therapy, cognitive behaviour therapy, interpersonal therapy, focal psychodynamic therapy and family therapy are mentioned. However, no information is offered on how these therapies work, or what therapy might work better for whom (with the exception of family therapy for adolescents with anorexia). The generality of this guidance is also reflected in the current Quality Improvement Scotland (QIS) guidelines adopted in 2006. These guidelines suggest that psychological treatments should be based on an individual psychological formulation. They add that treatments should focus on motivational enhancement, eating behaviour and attitude to weight, shape and any underlying psychosocial issues with the expectation that this occur alongside weight gain. Once more, there is a lack of clarity on precisely how these objectives should be met.

Clinical experience continues to be the main source of information regarding effectiveness of treatments, including psychotherapies. Following a systematic review of research, Kaplan (2002) suggested that in the last 30 years, fewer than 20 controlled

trials were identified which evaluated the effectiveness of various types of psychotherapy for anorexia. Other than family therapy in the treatment of young people, the evidence remains unclear and inconclusive. Some of these difficulties relate to small sample sizes (Channon et al, 1989), high drop-out rates from research studies (Serfaty et al, 2001), and limited descriptions of the theoretical and practical issues separating different therapies in comparative studies (Collier and Treasure, 2001).

In a series of overviews on therapy and therapeutic treatment organisation for anorexia, Woodside (2005) suggested there are "more questions than answers" and "more weaknesses than strengths in our understanding of the treatment of individuals with anorexia nervosa" (page 41). Details of some of the psychotherapies currently available to sufferers are presented in Table 3.

Table 3: Psychotherapies available for the treatment of anorexia nervosa

Psychotherapy Approach	**Formulation of anorexia.**	**Goals and tasks**	**Orientation**	**Lead Researchers / Clinicians**
Cognitive Behavioural Therapy	Anorexia is essentially a cognitive disorder, involving over-evaluation of eating, weight and shape control.	Explores feelings, educates the sufferer about body chemistry, and challenges the automatic thoughts and assumptions behind behaviour in anorexia.	Cognitive-behavioural.	Fairburn et al, (1999; 2003)
Cognitive Analytic Therapy	Anorexia is understood as a 'procedure', that is, a linked chain of mental processes and actions involved in the execution of aim-directed acts	Uses letters and diagrams to examine habitual patterns of behaviour relating to other people and to experiment with more flexible responses	Integrative (from psychoanalytic, personal construct theory and cognitive therapy)	Ryle, (l995;2002).
Interpersonal Psycho-Therapy	Based on aetiological theories that emphasise interpersonal and family dysfunction in the development of anorexia. Related interpersonal factors include problem areas of grief, interpersonal disputes, interpersonal deficits and role transitions.	Maps out the sufferer's network of relationships, selects a focus such as role conflict, transition or loss and works to generate new ways to manage distress.	Integrative (Psychodynamic and systemic).	Weissman et al, (2000). McIntosh et al, (2000) Burton, (1971)

Motivational Enhancement Therapy	Readiness to change is regarded as an important factor in therapeutic engagement and recovery.	Uses interview techniques derived from work within the field of substance misuse to reframe resistance and ambivalence to change and to nurture and amplify healthier responses. Intervention support the sufferer to take an active role in therapy and assume the individual possesses the capacity for change.		Prochaska and DiClemente, (1982) Miller and Rollnick, (1991) Vitousek et al, (1998) Geller, (2002) Vansteenkiste et al, (2005).
Cognitive Remediation Therapy	Cognitive rigidity is a key maintaining factor in anorexia. This includes cognitive deficits in set-shifting tasks, which involves being able to make decisions about moving between different tasks or operations.	Engages the sufferer in stimulating and positive mental activities, to improve thinking and information processing skills. Without the burden of complexity of confronting issues of emotions that relate to anorexia, it may be used before commencing another form of psychotherapy.	Neuropsycho-logical.	Delahunty and Morris, (1993). Tchanturia et al, (2004).

Dialectical Behaviour Therapy	Eating disordered behaviours evident in anorexia are viewed as emotion regulation or interpersonal strategies.	Deploy standard DBT model developed for the treatment of Borderline Personality disorder, making some adjustments for an eating disorder diagnosis. This includes broadening the theoretical and practical application. For example, developing eating disorder specific dialectics, highlighting eating disorder behaviours as treatment targets and adding a nutrition skills module.	Integrative (from CBT and Zen philosophy).	Wisniewski and Kelly, (2003).
Focal psycho-dynamic psycho therapy.	Anorexia can be understood in relation to experiences including early feeding processes and the mother-infant dyad, developmental arrest during the separation-individuation stage, body self development and the expression of psychological distress through somatic manifestation	Use psychodynamic principles in a time limited way to explore and understand ways of relating, whilst developing more helpful coping strategies through symptom reduction.	Integrative; Psychodynamic with CBT.	Johnson et al, (1987) Steiger, (1989) Gabbard, (1990) Tobin and Johnston, (1991).

The psychotherapies listed in Table 3 can be understood in two ways: some are primarily focused on establishing meanings about anorexia as an important prelude to change and recovery, while others aim to tackle and alleviate symptoms. Cognitive Analytic therapy, Interpersonal therapy, Motivational Enhancement therapy and Focal psychodynamic psychotherapy represent therapies that attend to meaning, whereas Cognitive Behaviour therapy, Dialectic Behaviour therapy and Cognitive Remediation therapy are more targeted towards addressing symptoms. While some of these modalities may have different philosophical backgrounds and underpinnings, reviewing the goals and tasks of each of these psychotherapeutic approach illustrates a general trend towards more technically-eclectic practice.

I will now discuss some of the dominant debates on the aims, goals and tasks of psychotherapy specifically under the umbrella of 'meaning-making' and 'symptom-alleviation' before discussing the trend towards psychotherapy integration in more detail. I will also explore available literature on sufferers' perspectives on the role of psychotherapy in recovery from anorexia as well as drawing upon relevant studies which explore subjective accounts of psychotherapy, employed to address other types of presenting problem.

2.6(1) Psychotherapies and the creation of meaning

Some authors have argued that the weight and shape concerns of sufferers of anorexia and the use of particular types of restrictive eating patterns have meanings beyond the fear of becoming fat and associated body image concerns. Hilde Bruch pioneered psychotherapy aimed at developing meaning. Developing a modified version of psychoanalysis, psychotherapy aimed to help the sufferer develop a stronger self-concept and identity. To achieve this, Bruch argued that the sufferer needs to experience her/his own capabilities at self directed action, self-regulation of individual needs and desires and the subjective experience of owning their body. She suggested the individual's needs, thoughts and actions must be altered to be experienced as of "fundamental importance" (1974, page 63). Bruch's psychotherapeutic approach became that of "fact-finding", what she named "the constructive use of ignorance" (1985, page 17). This task involves reconstructing what happened during the sufferer's early development and how the individual recalls their past. This approach values the

importance of exploring familial and other important interpersonal relationships and the relationship of these of the intrapsychic life of the sufferer and relies on the sufferer's own thinking. This reconstruction involves examining the emotional experiences during the pre-illness period and assisting the sufferer to recognise the adaptive nature of their behaviour and the repression of their genuine development.

However, the challenges of offering psychotherapy focused on meaning-making are significant. This modality can often take a long period of time. There is no treatment manual, or prescribed number of sessions, thus making it more costly and accessible to fewer people (Foster and Murphy, 2005). Furthermore, with all forms of psychotherapy, a positive outcome is by no means guaranteed, as sufferers frequently continue to live with significant physical and psychological difficulties and the feasibility of any empirical evaluation remains contentious (for example, Parry, 2000).

The rise of evidence based-medicine in the late 1990s has been critical of psychotherapies that are to unable to 'prove' the aetiological theories from which some psychotherapies are devised. From a more positivist research perspective, it is questionable if subjective meanings actually exist given that they cannot be replicated between studies because of their idiographic nature. Indeed evidence-based medicine values forms of psychotherapy practice and research that pursue similarities and generalities between sufferers' illness development and trajectory.

In addition, I believe the Minnesota study (Keys et al, 1950) has had a profound influence on psychotherapy practice. This study examined a group of male conscientious objectors to military service under conditions of semi-starvation over 168 days. It was the first to describe the psychological and behavioural changes induced by semi-starvation, including tiredness, irritability, apathy, loss of concentration, loss of libido, sensitivity to noise, emotional instability as well as an increased preoccupation with food. Some volunteers adopted new and different routines when eating. Some ate quickly; others ate slowly and savoured each mouthful. Some developed an increased preoccupation with food and would read cooking magazines. Others experienced significant emotional distress after eating, including the experience of guilt, or lost interest in things previously enjoyed such as social interactions. Following a period of refeeding, the majority of these cognitive, affective and behavioural changes subsided.

Significantly, this study concluded that some of the psychological and behavioural patterns seen in anorexia may be secondary to starvation and can resolve after weight restoration. In other words, some of the signs and symptoms associated with anorexia may not be unique features of a specific mental illness. Rather, they demonstrate the powerful effects of starvation on people generally, not just those with diagnosed eating disorders.

In terms of psychotherapy practice, this study encouraged clinicians and researchers to prioritise and address the problems uniquely associated with starvation states and low body weight. This has influenced treatment development, including psychotherapies which emphasise alleviating such symptoms either as the primary aim of therapy or as a prelude to other forms of psychological treatment.

2.6(2) Psychotherapies and the alleviation of symptoms

Some authors and clinicians clearly view anorexia as a mental illness developed through a combination of psychobiosocial vulnerabilities which are then triggered during a time of stress for the sufferer. In a position paper for the American Academy of Eating Disorders, Le Grange et al (2010) stated:

> The AED stands firmly against any etiological model of eating disorders in which family influences are seen as the primary cause of anorexia nervosa or bulimia nervosa and condemns generating statements that implies families are to blame for the child's illness (page 1).

These authors strongly cautioned against a 'blame culture' within aetiological explanations of anorexia and are concerned that families are seen as part of the problem, instead of a resource to support recovery.

It is understandable that for those who conceptualise anorexia in this way, the psychotherapeutic task should focus on the core cognitive, affective, physiological and behavioural symptoms of anorexia. Some authors (for example, Waller, 1993; McManus and Waller, 1995; Fairburn et al, 2003) have suggested that psychological treatments should be directed towards the "core cognitive content that is common to behaviours across all the eating disorders" (Waller, 1993, page 771). Fairburn (2008)

proposed that, "eating disorders and CBT are a perfect match because eating disorders are fundamentally cognitive disorders" (page 23). However, a substantial number of sufferers do not recover with CBT (Wilson, 1999) and the model has been revised to offer an additional protocol for eating disorders called CBT-E (the E standing for enhanced) which has added up to four treatment modules focusing on perfectionism, low self-esteem, interpersonal difficulties and mood intolerances. Fairburn (2002) argued:

> Just as oil and vinegar may be combined to dress a salad, so CBT and IPT may be combined in one single treatment. They cannot be integrated because of their procedural differences but they can co-exist (page 216).

Furthermore, the mood intolerances module in CBT-E borrows significantly from Linehan's model of Dialectical Behaviour therapy (Linehan, 1987) and specifically the distress tolerance module, although this is not made explicit by Fairburn. Nonetheless, both the language and teaching of distress tolerance skills come directly from it. This enhanced model of cognitive behaviour therapy does not, in practice, attend to the "cognitive disorder" but aims to address affect and interpersonal dynamics as part of therapy. It is also set to become the gold standard for the treatment of eating disorders and is widely discussed and publicised at national and international conferences. However, available evidence for this model suggests that at best half of bulimia sufferers recover, with less data available for anorexia sufferers (Gowers et al, 2007). Therefore, it would appear that the pursuit of symptom reduction in psychotherapy is no less complex and problematic than working with subjective meaning-making and treatment manuals are adapting to incorporate interventions which address issues beyond the core symptoms of anorexia.

In a paper titled *Bruch Revisited and Revised,* Skarderud (2009) proposed that Bruch's contribution was a descriptive and theoretical model defining anorexia nervosa as a *self-disorder*. He argued that despite the rise of therapies aimed at supporting symptom reduction, such as cognitive behaviour therapy, there is a lack of underlying theory, or in other words, no conceptual tool to guide the therapeutic transactions. Skarderud appeared to favour a theoretical integration in the psychotherapeutic treatment of anorexia. Theoretical integration aims to create a conceptual or theoretical development beyond the technical application of psychotherapy methods. By synthesising two or

more approaches to psychotherapy, theoretical integration aims to create an emergent theory.

2.6(3) Addressing meaning and symptoms: The importance of psychotherapy integration

Table 3 highlights pluralism in the psychotherapeutic treatment of anorexia and a growing preference in practice towards integrative approaches. It also highlights a move away from an either/or approach to meaning-making or symptom reduction as the focus of psychotherapy and a recognition of the value of being able to offer sufferers both options.

This is a central principle of Motivational Enhancement therapy. There was considerable excitement and optimism starting in the 1990s about the introduction of Motivational Enhancement techniques borrowed from the field of addictions. Founded on the notion that any treatment, including psychotherapy should be matched to sufferers' readiness to change allowed sufferers to explore and create meanings about the perceived advantages and disadvantages of living with anorexia. The central premise is that the sufferer will not be able to focus on change if they perceive this is being imposed upon them. Motivational Enhancement Therapy is not only a method of conducting therapy, but offers a conceptual framework based on readiness to change within which decisions can be made about treatment selection, for example, engaging in more change-focused therapies such as CBT if the sufferer is ready to do so.

Although initially yielding some promising results (Geller, 2002), it has not proved to be as effective as once thought. The principle of working collaboratively with the sufferer and taking a non-confrontational approach to resistance to change has not, rather surprisingly, produced superior results in practice or in research. Indeed research focused on therapist competence in motivational interviewing by Miller and Rollnick (2009) found "near zero correlation between clinicians self-perceived competence and their observed actual proficiency (page 136). If results of this study are to be taken as representative of clinical practice then this implies that there is a significant discrepancy between perceived and actual competence, with the most confident therapists likely to be the least competent. During a presentation at the 10th London International Eating

Disorders Conference in March 2011, Vitousek discussed a growing opinion about this approach to treatment and the claims that it prepares people to change across all mental health difficulties. She suggested, "Recently, we've started to feel somewhat let down by motivational methods because they didn't do the trick, after all". Therefore, as with all other psychotherapies discussed so far, Motivational Enhancement Therapy appears not to be a panacea either.

Returning to explore Table 3 more critically, I believe that while sufferers have choice in psychotherapy treatments, multiple and sometimes divergent formulations of anorexia co-exist, with different psychotherapeutic modalities prioritising and privileging particular therapeutic endeavours, whether learning, support or action factors.

Reviewing the range of psychotherapies available to sufferers of anorexia emphasises this stark divergence in approaches, as well as the lack of clarity about what works best for whom. It is similar to the Dodo Bird Verdict in Alice in Wonderland, where "Everyone has won and all must have prizes". Understandings of developing anorexia are dominated by the views and beliefs of clinicians and academics and these views are then filtered through to inform treatment, including psychotherapeutic interventions.

This would not necessarily be problematic if recovery rates were higher and treatments including psychotherapies, were more advanced and had established a track record in successfully supporting sufferers in their recovery process. However, current information on prevalence, mortality, duration of illness, length of time to recover and longer term outcomes sets a more worrying scene for sufferers. From such a position, it is essential to better understand what sufferers of anorexia find helpful from their treatments, and in particular, their experience of psychotherapy. In addition, it is important to review available research from the perspective of the recipient of treatment to critically assess what clinicians and researchers are drawing upon to help inform practice.

2.7 Sufferers' perspectives on the role of psychotherapy in recovery from anorexia

There has been a growing interest in and commitment to the involvement of service-users both in developing mental health services and reviewing patient/client satisfaction of them (Department of Health, 1999). The notion that 'doctor knows best' has been updated with an increased emphasis on patient opinion and a developing awareness that patient satisfaction is not merely a customer service aspiration, but directly influences the effectiveness of the interventions being offered. In other words, people who are satisfied with treatment are more likely to have experienced it as effective and supportive of recovery.

One component of this has been the identification of the views and perceptions of service-users of both the treatment they have received, and the structure of services, including ease of access, waiting times, and availability of treatment facilities (Mayo et al, 2001), appropriateness, efficiency and quality of care (Donabedian, 1980), and acceptability and humanity of treatments (Higginson et al, 1994). This has contributed to a treatment context where it is increasingly relevant and customary to seek people's views and feedback on their subjective experiences of treatment.

There are a small number of studies which have explored the views of people with eating disorders in relation to their treatment experiences (for example, Yager et al,1989; Newton et al, 1993; Rorty et al, 1993; Clinton et al, 2004; Halverson and Heyerdahl, 2007) and a smaller number which focus specifically on psychotherapy (De la Rie et al, 2008; Whitney et al, 2008). Given my particular interest in exploring sufferers' subjective experience of psychotherapy as a treatment intervention, I intend to explore each of these studies in some detail. I will review what these studies currently contribute to knowledge in the field of anorexia and elucidate important areas that require further exploration.

Yager et al, (1989) examined help-seeking and satisfaction with care in 641 women with a range of eating disorders in the United States. Using a help-seeking and satisfaction questionnaire issued in Glamour Magazine, the authors found that individual psychotherapy (52.9%), behavioural therapy (28%), group therapy (24.6%) and

nutritional therapy (18.6%) were recorded as the treatments most commonly sought by sufferers. Using ratings of the extent of change and attribution of change due to treatment scores, the author developed a scale of perceived efficacy of treatment. They conclude that treatments were generally seen as helping "a little" and suggest that reports from established eating disorder treatment centres frequently provide improvement figures that are much higher than those within their study and fail to capture the experience of people who drop out of treatment.

Newton et al, (1993) examined treatment for eating disorders in the United Kingdom. The authors used a postal survey with members of the Eating Disorders Association (now called b-EAT) to ascertain the views of a large group of individuals with experience of eating disorders on the treatment they had received, and their perceptions of the need for improvements in the management of eating disorders. Given the opportunity to comment on 7 different treatments (Family doctor; Outpatient treatment - including individual psychotherapy, behavior therapy, group therapy, family therapy and medication; Hospital inpatient treatment; Counselling; Other Treatments, Private treatments and Self-help groups), counselling was rated most favourably, with self-help groups scoring second highest. Medication, group therapy, family therapy and inpatient care were rated as helpful by half of the respondents. Behaviour therapy was rated as rather unpopular. Although counselling (as well as all the forms of therapy) is not defined in the study and can therefore be assumed to cover a variety of theoretical and practical approaches, the authors conclude that both counselling and self-help groups share the characteristic of not usually being medically-led. They also add that they rely on 'talking though problems' without highly structured interventions. They argue that commissioners of services should include these interventions in the range of services for people with eating disorders.

Rorty et al, (1993) explored why and how women recover from bulimia nervosa. Using semi-structured interviews with forty female sufferers, the authors describe the range of treatments offered, which include individual and group therapy, nutritional advice, and medication. Interventions were deemed most helpful when characterised by empathy and understanding. Concerns about the therapist or the treatment strategy were included in the least helpful treatment-related experiences, although the authors do not describe examples that would constitute such concerns, what they describe to be "Therapist-

specific complaints" and "Treatment strategy-specific complaints" (page 255). The authors conclude that sufferers should be treated as a whole person and not merely "a symptom constellation" (page 259).

Clinton et al, (2004) examined patient satisfaction with treatment in eating disorders. Satisfaction with treatment was measured using a structured questionnaire with four hundred and sixty-nine participants, 36 months after initial assessment for treatment across multiple treatment centres. The questionnaire focussed on initial reception at the treatment centre, suitability of treatment, ability of staff to listen and understand, confidence in the treatment centre and agreement on treatment goals. When participants' experiences of treatment interventions were examined, the data suggested that strategies focussing on controlling eating habits and support were the best predictors of overall satisfaction. However, over a quarter of the participants were judged as being unsatisfied with treatment. Unsatisfied participants had previously been less prepared to change their eating habits, had higher levels of conflict with their fathers, had a lesser degree of present weight acceptance and tended to expect less from treatments aimed at controlling eating difficulties. They conclude that these findings raise the question of the role of the patient-therapist relationship for outcome and the importance that therapists listen more carefully to their clients and discuss expectations when planning and providing treatment.

Halvorsen and Heyerdahl (2007) investigated perceptions of treatment with forty-six former patients with anorexia nervosa and fifty-nine parents to determine if this was related to outcome or treatment characteristics. Using structured questionnaires, the authors found that parents had a positive perception of treatment whereas former patient perceptions were generally more negative. However, they did not find a correlation between perception of treatment and eating disorder symptoms when the participants were followed up. Indeed, they found that outcome was positive, despite lower levels of satisfaction with treatment than their parents. Nonetheless, the authors noted that none of the participants dropped out of treatment and all has completed a course of "long-term treatment" (page 636). The authors also found that former patients tended to rate items related to the therapeutic alliance positively, indicating that there was a moderate degree of satisfaction with treatment, albeit lower than their parents' degree of satisfaction with treatment.

Looking more specifically at patient/client's experiences of psychotherapy, De la Rie et al (2008) developed a study aimed at investigating the quality of treatment for eating disorders both from a therapist and patient perspective. Although therapists and patients shared agreement on the merits of focusing on treatment, the therapeutic alliance and communication skills, they valued specific topics differently. For example, therapist participants in the study emphasised the focus on eating disorder symptoms and behaviour change, whereas patient participants underscored the importance of the relationship with the therapist and addressing underlying problems. Indeed the ranking of factors relating to the quality of treatment of eating disorders by current and former patients was:

1. Trust in therapist
2. Being taken seriously
3. Treatment that addresses the person
4. Being able to talk about feelings
5. Focus on self-esteem
6. Being respected
7. Being able to talk about thoughts
8. Addressing underlying problems
9. Being able to talk about eating behaviours
10. Being accepted as you are.

Given the possibility of differing priorities, goals and tasks between therapist and client within psychotherapy, it is not surprising to see the discrepancy in views illuminated in this study.

Research that specifically draws upon sufferers' perspectives of psychotherapy (and not a more generic description of 'treatment', which may or may not include psychotherapy) is almost non-existent. This is both surprising and concerning, given the central place given to psychotherapy in the treatment of eating disorders, the significant move towards service-user feedback in the arena of mental health service delivery, and advances in psychotherapy research elsewhere, which places much more value on the perspectives of

recipients of psychotherapy (for example, Clark et al, 2004; Duncan and Miller, 2000; Elliott and James, 1989; Heppner et al, 1992). As Duncan and Miller (2000) argued:

> It is the clients, not the therapists, who make treatment work. As a result, treatment should be organised around their resources, perceptions, experiences, and ideas (page 11).

One published piece of research which examined anorexia sufferers' views of psychotherapy is a small qualitative study exploring patient perspectives of Cognitive Remediation Therapy (CRT) (Whitney, et al 2008). In this study, they sought verbal and written feedback on this psychotherapy approach. The study found that most participants viewed this approach as refreshing and appreciated that it did not revolve around food. It also taught thinking skills that participants hoped they would be able to transfer onto day-to-day decision-making tasks. As discussed in Table 3, CRT is a model of psychotherapy aimed at alleviating and managing symptoms of anorexia (in this case, neuropsychological deficits), rather than creating meaning about the role and function of anorexia in the sufferer's life. On one hand, the information for this study is helpful in that it represents an attempt to hear directly from sufferers about their views of this particular form of psychotherapy. However, CRT as a psychotherapy approach is situated in the aetiological school that views anorexia as a mental illness and essentially a disorder of the brain. From such a perspective, meaning-making is both irrelevant and potentially harmful in falsely attributing blame for the development of anorexia outside of the sufferer's genetic and biological vulnerability.

In summary, there are a small collection of studies which seek to explore the views of recipients of eating disorder treatment. Table 4 summaries some of the methodological characteristics of the studies, their research aims and findings.

Table 4: Studies that explore suffers' views of treatment

Author / Year	**Country**	**Participants**	**Method of data collection**	**Treatments reviewed**	**Findings**
Yager et al (1989)	USA	641 women (age 18 and above) AN/BN/ EDNOS	Magazine survey	Professional Treatments:- Behaviour modification, Group therapy, Hypnosis, Nutritional counselling, Medication	Professional Treatments – Individual Therapy, Behaviour Therapy, Group Therapy and nutrition Therapy helped a little.
Newton et al (1993)	UK	1638 -1599 female / 39 male (age 18 and over) AN/BN/Other	Postal Survey	Family doctor, Outpatient treatment*, Hospital inpatient treatment, Counselling, Other treatments, Private treatment, Self-help groups (* Outpatient – Individual psychotherapy, Group therapy, Behaviour therapy, Family therapy, Medication)	Counselling and self-help groups most helpful. Behaviour therapy unpopular.
Rorty et al (1993)	USA	40 Women (age 18 and over) BN	Semi-structured Interviews	Individual sessions with mental health professional (Psychiatrist, Psychologist, Social Worker, Marriage/Family/Child Counsellor, Therapist) Meeting non-psychiatric physician Nutritionist or Dietitian Group therapy	Empathy and understanding most valued aspect of treatment.
Clinton et al (2004)	Sweden	469-462 female/ 7 male (age 18-51) AN/BN/ EDNOS	Structured Questionnaire	Multi-centre study (15 treatment centres) offering inpatient / day / outpatient programme and offering individual, family and group therapy, medication and "expressive treatments".	38% highly satisfied 39% satisfied 23% unsatisfied Strategies focussing on active control of eating habits and support were best predictors of overall satisfaction.

Halverson and Heyerdahl (2007)	Norway	105 -46 female AN patients, 33 mothers, 26 fathers.	Structured Questionnaires	Exploration of perceptions of treatment. To determine if perception of treatment related to outcome or treatment	Parents more positive than sufferers in their perception of treatment. No correlation between perception of treatment and eating disorder symptoms at follow up.
De la Rie et al (2008)	Netherlands	304 -gender not specified (27 years average age) AN/BN/ EDNOS	Structured Questionnaires	Exploration of the quality of treatment from both patient and therapist perspective	Shared treatment priorities: therapeutic alliance, focus on treatment, communication skills. Therapist's prioritised ED symptoms and behaviour change. Patient prioritised relationship and addressing underlying difficulties
Whitney et al (2008)	UK	29 female (age range 17-54) AN	Written feedback following 10 CRT sessions	10 sessions of CRT	Positive feedback from patients – "refreshing approach that does not revolve around food". Helped to reduce perfectionism and rigidity.

Samples from the 7 studies include 3216 participants (gender is not always specified, minimum of 46 male participants). Studies were conducted in the following countries: 2 in the United Kingdom, 2 in the United States of America, 1 in Sweden, 1 in Norway and 1 in the Netherlands. All of the studies included participants over the age of 18 years. Inclusion criteria based of eating disorder diagnosis varied between studies: 2 explored the views of people with anorexia nervosa, 1 explored the views of people with bulimia nervosa and 4 explored the views of people with anorexia nervosa, bulimia nervosa or an unspecified eating disorder.

Although each study has different aims, methodologies and findings, they can be grouped according to three central objectives:

1. An examination of treatment characteristics (the specific components of helping interventions). Three of the studies investigated treatment characteristics (Newton et al, 1993; Rorty et al, 1993; De la Rie et al, 2008);
2. An examination of sufferer outcomes based upon treatment modalities (what worked for whom). Two of the studies investigated the outcome of different treatment modalities (Yager et al, 1989; Whitney et al, 2008), and
3. An examination of the relationship between patient-satisfaction with treatment characteristics and the outcome of treatment. Two of the studies investigated the relationship between satisfaction with treatment characteristics and outcome (Clinton et al, 2004; Halverson and Heyerdahl, 2007).

These studies have produced mixed findings but indicate a broad theme that sufferers' tend to value the therapeutic alliance with members of their treatment team and are less satisfied with treatment elements aimed at coercively restoring physical health if they are not ready to do so. These findings are significant when reviewed alongside current professional guidelines which emphasise the importance of weight restoration as a treatment objective. Indeed, this suggests that the very interventions that clinicians are being asked to prioritise are those valued least or experienced as most challenging by some recipients of them.

Turning more specifically to psychotherapy as a treatment approach, these findings are consistent with those of Beresin et al (1989), which found that psychotherapy was

judged positively when the therapeutic relationship was characterised by support, empathy, respect, understanding and being seen "behind the symptoms". They also support a study by Zeeck and Hartmann (2005) which explored the link between therapeutic process and outcome. They found that when sufferers of anorexia experienced sustained negative thoughts and feelings between sessions about the therapist or the content of the session, this was indicative of a poor therapeutic alliance and linked to a poorer outcome. Conversely, a frequent and intense process of remembering therapy between the sessions was found to be associated with a good outcome. Moreover, this has also been found in more generic psychotherapy research, highlighting that patient/client's perspectives on satisfaction with and contributions towards their psychotherapy has been strongly linked to outcome (Halstead et al, 1990; Hubble et al, 1999; Lambert, 2004; Marziali, 1984).

A limitation of these studies is that they use the overarching term 'treatment', which includes a broad and diverse range of interventions, from bed rest within inpatient treatment to psychotherapy. When psychotherapies are mentioned, they are not defined theoretically or practically and as a result it is difficult to know what is being examined. In addition, 5 out of the 7 studies focus on the treatment experiences of sufferers of a range of eating disorders, yet one would anticipate that the nature of treatment for people with anorexia may involve more coercive aspects surrounding weight restoration and the stabilisation of physical health as well as longer treatment episodes.

If, as these studies suggest, sufferers are generally offered a range of different psychotherapeutic modalities, it would be beneficial for clinicians to better understand if there are particular models of psychotherapy that the recipients of them find more or less helpful and to gather more detailed information about what occurs within therapy. Alternatively, another way of investigating this issue would be to examine if there are particular commonalities or shared therapeutic factors that exist across a range of psychotherapy approaches.

As a result, within this study, I intend to explore a range of psychotherapy approaches, rather than focusing on a particular modality. I will examine both technical and non-technical aspects of psychotherapeutic interventions and seek to further elucidate the role of the therapeutic alliance as an aspect of what makes psychotherapy helpful.

2.8 Discussion of the literature reviewed

The literature on aetiologies of anorexia, recovery and the role of psychotherapy in recovery is complex and includes a vast range of perspectives. Despite discussion in more recent literature about a trend towards multi-dimensional and multi-disciplinary perspectives on these three areas, there continue to be points of clear divergence and dispute. This is further complicated by the socio-political aspects of health research and the power struggles that persist between the schools of thought listed in section *2.2*.

The pursuit of knowledge in the field of anorexia research is by no means a neutral process and is bound by the creation of hierarchies of evidence and the associated power dynamics that emerge from this. This includes debates on the credibility of various types of research, with randomised control trials enjoying the privileges of creating findings that are apparently valid and reliable. This ensures that more medical and clinical psychology orientated research has access to research funding and their epistemological positions dominate as a result. In the middle of such power struggles, the voices of those with personal expertise of anorexia are marginalised and significantly under-represented in the literature. Their voices are more apparent in popular culture media such as autobiographies, magazine articles and websites. However, all contexts influence the information provided within them, and these mediums also directly inform and affect the information provided. For example, the sensationalist stories and pictures in tabloid newspapers frequently offer a trivial and voyeuristic exploration of anorexia. Within these mediums, I believe the aim is to provide a 'good story', something dramatic, titillating yet simplistic and not a holistic representation of the sufferer's experience, which may or may not be any of these things.

In addition, when reviewing the small number of studies on developing anorexia and recovery from the perspectives of sufferers, I was aware that there are limitations to these studies. On the one hand, they are very important in offering sufferers a voice. They are intriguing and have connection to some of the debates on developing anorexia and recovery within the academic literature. For example, some of the participants in these studies allude to a variety of factors that they perceive to be relevant in the development of their eating disorder. These are sometimes the same factors cited in clinical research, for example, the role of stressful life experiences in the development of

anorexia or the link between unhelpful family relationships and developing eating disorder difficulties. However, it is also apparent where there are points of divergence between sufferer perspectives and some of the academic perspectives within the literature. A notable example is the theme from sufferer perspectives that treatment focused on weight restoration is valued less than interventions which are more person-centred in their goals and tasks.

On the other hand, the research methods deployed in studies that explore sufferers' perspectives and the presentation of findings is undertaken in a way which appears to divorce the meanings of recovery both from participants' broader life experiences and from their personal representations of developing anorexia in the first place. Therefore when reviewing these studies, I found myself questioning the *significance* of recovery factors in the absence of a more embedded narrative context; for example, not merely describing what important recovery factors are but helping to illuminate *why* certain recovery factors are important.

In addition, it is concerning and disappointing to see that current studies which seek to explore the role of psychotherapy in recovery from anorexia, from the perspective of those who have been the recipients of psychotherapy are limited to just two studies (De la Rie et al, 2008; Whitney et al, 2008). This is a significant gap in the available knowledge base for a number of reasons. Firstly, this highlights that this area of eating disorder research is lagging behind other psychotherapy research that explores the experience and value of psychotherapy from the client perspective. This area of research will be discussed further in section *3.4*. Secondly, this perpetuates the unhelpful position that sufferers of anorexia have little to teach about how to develop and improve psychotherapy interventions. It maintains the position where sufferer perspectives are trusted and valued less than other perspectives. Authors such as Mishler (2005) criticised the way in which subjective narratives are excluded from official knowledge production, even when they have a clear relevance to those establishments that aim to offer treatment and support. Stone-Mediatore (2003) also held this view, suggesting:

> Patient stories were excluded until quite recently from precisely those settings in which we might have expected them to be most relevant. Specifically, they were neither elicited nor responded to in those places

> where we go for help in understanding and managing our symptoms, complaints and illnesses, hospitals, clinics, physicians' offices (page 434).

Thirdly, available literature on the role of psychotherapy in recovery from anorexia often comes from and values particular psychotherapy orientations. For example, it is reasonable to expect that researchers from a particular therapeutic orientation would seek to produce findings which validate the effectiveness of that approach. What is currently lacking is a study which possesses no affinity to one psychotherapy approach and which is primarily focused on hearing how sufferers themselves give meaning to what was most important for their realisation of change and recovery.

Moreover, if psychotherapy does have a role in supporting recovery, it seems essential that clinicians have a better understanding of this and consider the implications for future practice. In other words, allowing the expertise of subjective experience to teach clinicians and academics something and to add this to the available knowledge base.

In summary, a review of available literature has enabled me to identify particular areas that have not yet been explored in detail and which this research will examine further. Firstly, I intend to examine subjective accounts of recovery alongside personal representations of developing anorexia in order to highlight potential meanings and understandings about the relationship between the two. Secondly, I shall examine subjective accounts and understandings of the psychological changes that support the recovery process. In particular, I intend to explore the role of professional and non-professional help in supporting the recovery process and the relative contribution of each. Thirdly, I will examine the particular factors that make psychotherapy helpful. This will include both technical and non technical aspects of psychotherapy, such as particular therapeutic interventions and the role of the therapeutic relationship.

These areas of further examination can be turned to the following questions:

1. What does it feel like and what does it mean to develop anorexia?
2. What does it feel like and what does it mean to recover?
3. What is the role of psychotherapy in a sufferer’s recovery process?

3 Methodology

3.1 Introduction

Having arrived at the overall aim of this research - to examine subjective accounts of the role of psychotherapy in participant's recovery from anorexia nervosa, the following objectives were identified:

1. To gather personal accounts of the experience of developing anorexia, recovery and the role of psychotherapy;
2. To explore ideas and meanings emerging from data collection in a systematic way;
3. To analyse findings in relation to the data and the existing literature in order to develop theoretical meanings; and
4. To identify and explore potential implications for psychotherapy practice.

A qualitative research paradigm is appropriate for studies attempting to explain the nature of a phenomenon and the nature of the social processes surrounding that phenomenon (Guba, 1978). Qualitative research is particularly well suited to illustrating the nature of people's experiences with profoundly sensitive occurrences like illness (Strauss and Corbin, 1990). Qualitative research methods do not rely on strict, prescribed research steps, but instead are characterised by certain "ways" of coming to know the subject through iterative cycles of deep engagement with the data (Smith et al, 2009; van Manen, 1990). Although the purpose of gathering data is to generate and construct theoretical meanings relating to recovery from anorexia and the role of psychotherapy (see Glaser and Strauss 1967; Strauss and Corbin, 1990), such theoretical meanings are not intended to produce a comprehensive theory relating to the role of psychotherapy in recovery from anorexia. This research seeks to provide partial theoretical meanings based on sufferers' perspectives, and more accurately, the perspectives of the participants in this study. Theoretical meanings are then examined in

relation to other types of research about developing anorexia, recovery from and the role of psychotherapy within the recovery process.

To achieve these research objectives, a number of tasks were undertaken. These include acquiring ethical approval, identifying and recruiting participants, undertaking data collection with research participants, systematically analysing data and presenting findings. Central to all of this is my awareness of the importance of ethical practice in decision-making during each stage of the research process and a commitment to reflective and reflexive research practices. I will begin by exploring the philosophical roots of this study.

3.2 Exploring Human Experience

Phenomenology is a philosophical approach to the study of human experience. Human experience includes what matters to us, how we might describe our relationship to things, people and events and what it might mean to experience particular things. Phenomenology emerged at the beginning of the twentieth century in Germany as a fundamental critique of modern natural science, which had removed itself, through positivist reductionism from a more 'ordinary' sense of everyday life. Husserl (1927), Heidegger (1962; 1927), Merleau-Ponty (1962) and Sartre (1948; 1965; 1969) are leading figures in phenomenological philosophy. Phenomenologists such as Husserl argued that modern natural science created an abstract world of its own. Phenomenology, with its roots in the experience of everyday life, *'Zu den Sachen selbst'* (to the things themselves) (Spielgelberg and Schuhmann, 1982) advocates a return to lived experiences and perceptions.

Philosophical literature on phenomenology is expansive and complex. Husserl is considered to be a founding father of the Descriptive-Transcendental account of phenomenology which was concerned with discovering the essence of phenomena and even strived to understand the nature of consciousness of a person engaged in experience (Smith et al, 2009). To achieve this aim, Husserl (1927) advocated a phenomenological *attitude*, which involves a reflexive shift from objects in the world (for example, an illness 'anorexia') towards our own perceptions of those objects (for example, how we

think about, make sense of and understand the experience of anorexia). This requires a focus on the consciousness of the individual, as well as adopting an intentional relationship between the conscious process and the object of attention. The method which Husserl described, the 'eidetic reduction', moves through a sequence. Each part of the sequence offers a different way of contemplating or understanding the phenomena being explored. Aspects of the Husserlian 'reduction' include:

- A reflexive move towards understanding our own experience, which involves shifting our 'natural attitude' (our everyday assumptions about how things are) to the 'phenomenological attitude' (a more focussed approach to understanding things as we experience them);
- Suspending our 'natural attitude' through a process of bracketing (identifying and then setting aside) our own fore-understandings to examine experience itself. To do so, we need to bracket off culture, context and history, and
- Allowing this process of abstraction to identify essential properties of the experience – "that which makes a thing what it is (and without which it would not be what it is" (van Manen, 2003, page 177).

By progressing through this sequence of reductions, Husserl suggested the enquirer can turn away from the distractions of prior assumptions and preconceptions and towards the *essence* of the given phenomena. The notion of essence is important for Husserl who conceived that within human experience there is a fundamental or absolute meaning that can be sought. Applying the concept of an 'eidetic reduction' to this study, the aim would be to arrive at the essence or essential meanings of developing anorexia, recovery and the role of psychotherapy in recovery from the perspectives of the participants.

However, other philosophers, such as Heidegger (1962; 1927), Merleau-Ponty (1962) and Sartre (1948; 1965; 1969) who founded the Hermeneutic-Existential account of phenomenology argued that it is impossible to make Husserl's reduction because our observations are always made from a situated perspective. This relates to the concept of being 'thrown' in the world – that we are 'always-already' engaged and involved in the world and in our relationships with other people. We cannot step into an objective realm outside of our world. Accordingly, these philosophers recast the phenomenological

enterprise, focusing on the existential and hermeneutic dimensions of meaning-making and underlining the embeddedness of our historical and cultural context.

Hermeneutics offers a theory of interpretation and is concerned with the methods and purposes of interpretation itself, whether it is ever possible to find *original* meaning ('essence') and the relationship between context and a text's interpretation. Theorists such as Heidegger (1962; 1927), Gadamer (1990; 1960) and Schleiermacher (1998), have been leading figures in the exploration of hermeneutics.

Heidegger (1962; 1927) saw interpretation as inevitable and the best we can manage in getting closer to human experience:

> Whenever something is interpreted as something, the interpretation will be founded essentially on fore-having, fore-sight and fore-conception. An interpretation is never a presuppositionless apprehending of something presented to us. Understanding always pertains to the whole of Being-in-the-world (page 191-192).

As a result, the person who seeks to understand the other brings their fore-structures (prior experiences, assumptions, and preconceptions) to the encounter and "cannot help but look at any new stimulus in the light of their own prior experience" (Smith et al, 2009, page 25).

Heidegger (1962; 1927) therefore suggested:

> Our first, last and constant task in interpreting is never to allow our fore-conceptions to be presented to us by fancies and popular conceptions, but rather to make the scientific themes secure by working out the fore-structures in terms of the things themselves (page 195).

Gadamer (1990;1960) emphasised the importance of history and tradition on the interpretative process. He proposed that the process of interpretation itself can illuminate the interpreter's fore-structures and even alter them. For Schleiermacher (1998), interpretation was as much about understanding the author as it was the text, suggesting there is something unique about the techniques and intentions of the writer which will influence the writing of a text and the reader's interpretation of it.

These issues can be managed by the concept of the hermeneutic turn (Smith et al, 2009, page 34). The hermeneutic turn involves the dynamic process which includes a combination of phenomenological and interpretative aspects of phenomenology. Phenomenological insights are acquired by seeking to get as close as possible to the personal experiences of the other – seeking an 'insider perspective'. Interpretative insights are acquired by acknowledging the prior assumptions, preconceptions and theories that the interpreter brings to the sense-making process and creating a dialogue between such fore-structures and the teller's first-hand accounts.

Finally, phenomenological enquiry from the Hermeneutic-Existential phase is idiographic and idiography is concerned with the particular. By privileging the particular, idiography seeks to explore how experiential phenomena can be understood from the perspective of particular people, situated within a given context. It is necessarily committed to exploring detail. Merleau-Ponty (1962) and Sartre (1948; 1965; 1969) offered a perspective of the individual situated and immersed in a world of objects and relationships, language and culture, projects and concerns. They advocated for a perspectival directedness of our lived experience, something subjective but equally belonging to our relationships in the lived world. Accordingly, idiography does not promote the creation of generalisations. Indeed, Harre (1979) argued that an alternative way of establishing generalisations is locating them in the particular and arriving at them more tentatively – in other words, allowing a person to offer a unique perspective on their relationship to, or involvement in the phenomena of interest.

3.2(1) Situating my phenomenological attitude

In order to get closer to the lived experience of research participants, Churchill et al (1998) advocated for an intuitive "empathic dwelling" (page 65) as the first step in the process. Davidson (2003) described empathy as:

> A highly disciplined and demanding posture involving an active and artful use of all of one's faculties of memory, imagination, sensitivity, and awareness in coming to understand another person's experience from his or her own perspective (page 121).

When considering the intentional use of empathy to assist in achieving a Husserlian reduction, it occurred to me that I had spent many years both in my social work and psychotherapy trainings learning about and seeking to acquire and refine empathic skills. In other words, I was 'taught' empathy as a psychotherapeutic technique. Prior to my professional trainings, I had acquired an experiential understanding about empathy in my day-to-day life with particular people and situations, but I learned more about empathy and cultivated an enhanced capacity to 'dwell empathically' as a result of my professional trainings. Arising from this is a question: - is the use of empathy an example of the phenomenological attitude that Husserl promoted or does it reflect the kind of theoretical presupposition that is to be avoided? I believe the answer is that it is both. Being a psychotherapist necessarily influences how I might interpret the world, but it also informs how I now experience it. Accordingly, my psychotherapeutic knowledge, skills and experiences not only influences how I might interpret the lived experiences of my participants but also informs how I 'experience them'. Finlay (2008) who is both a psychologist and a researcher discussed this issue when conducting her own research. She asked:

> Should I have put out of play the skills and understandings I have acquired over the years as a therapist and academic in the field of psychology? The answer to this question is both yes and no (page 28).

She goes on to argue that the research interview (as opposed to a philosophical reflection) means that particular practical and social pre-understandings required for phenomenological psychology research were brought into her decision-making. She continued:

> In the case of this research, my therapist/psychology background are so much a part of me (and the habitualities of my 'natural attitude). I could not have maintained them a-part from me (page 28).

This position resonates closely with my own. I would situate my phenomenological attitude within a Hermeneutic-Existential stance. I prefer a formulation of fore-structures which acknowledges and respects the deeply embedded nature of our prior assumptions, beliefs and preconceptions on the human psyche and the subsequent process of meaning-making. Indeed, I question the human capacity to sincerely bracket

fore-structures and wonder what interpretive apparatus an individual is left with in their absence.

Nonetheless, while my 'throwness' means that I will never be able to fully arrive at the essence of my participants' experiences and my understandings are and will always be, to a greater or lesser extent, from 'side-ways on', it has been possible to carefully identify and reflect on my own experiences, preconceptions and assumptions and consider their impact on my methodological decision-making. I have tried to remain open to whatever emerged during the study whether engaged in the phenomenological or interpretative stages of the hermeneutic turn to connect both experientially and conceptually with my participants and their personal accounts of developing anorexia, recovery and the role of psychotherapy in the recovery process. As a result, rather than seeking to engage in bracketing as a permanent state throughout this study, I have aimed to 'suspend' (van Manen, 2002) my fore-structures while in the phenomenological part of the hermeneutic process, allowing a more deliberate use of them during the interpretative part. Therefore the phenomenological and interpretative aspects of my study are mutually constitutive.

Applying Harre's proposition about the generalisability of findings, by exploring the 'particular' subjective accounts of participants who have developed and recovered from anorexia, and utilised psychotherapy to assist their recovery process, this creates the potential to generate important themes or understandings that relate to these *particular people*, at a *particular time*, in a *particular context*. The themes and understandings generated from this phenomenological enquiry may or may not generalise between participants, or with a broader audience of sufferers. The aim is to respect each individual account without *requiring it* to share commonalities with other accounts. It is this phenomenological attitude that I brought to the methodological process and which is revisited throughout this thesis.

3.2(2) Summary on exploring human experience

The fundamental aim of this study is to explore human experiences of anorexia and the philosophical underpinnings of the study are rooted in a Hermeneutic-Existential approach to phenomenology. Having established this, the method of accessing human

experiences of anorexia had to be decided before moving on to consider the most useful way of interpreting such phenomenological data. In other words, I needed to consider the ways that people represent or describe their experiences to others (in this case how participants communicate their experiences to a researcher) and how people make sense of the experiences of others (in this case how the researcher interprets participants' subjective accounts). In *3.9(1)*, I will explore these processes in detail. In the meantime, I will return to the issue of selecting an appropriate methodological strategy that would allow participants to share and describe their personal experiences of developing anorexia, recovery and psychotherapy.

3.3 Narrative and Interpretive Phenomenology

To generate accounts of developing anorexia, recovery and the role of psychotherapy, a data collection method was required that would generate rich, detailed, first person accounts of subjective experience. A decision had to be reached on how to elicit this form of data about the target phenomena. Gee (1985) suggested that "one of the primary ways – probably *the* primary way – human beings make sense of their experience is by casting it in a narrative form" (page 11). Similarly, Cohler (1982) argued that we learn to tell stories as children and they become "the most internally consistent interpretation of presently understood past experience, experienced present and anticipated future" (page 207). In addition, MacIntyre (1981) asserted:

> it is because we all live out narratives in our lives and because we understand our own lives in terms of narratives we live out that the form of narratives is appropriate for understanding the actions of others. Stories are lived before they are told - except in the case of fiction (page 197).

Given the contention that personal narration is a fundamental way of making meanings in our everyday lives, its application as a research method has become increasingly popular since the 1980s (for example, see Josselson and Leiblich, 1993; Reissman, 1993) and offers the potential to access the rich, detailed subjective accounts this study aims to generate.

Interpretive phenomenology is not a single method, nor is narrative enquiry. For example, some narrative research is concerned with the examination of life histories (Chamberlayne et al, 2000). Such biographical narrative research assists to discover and deconstruct how people make sense of the things that happen to them. Interpretation of biographical narratives will attend to the host of socio-cultural factors that impinge on our meaning-making in the world. Other types of narrative research pay attention to the more internal aspects of experience, such as intrapsychic and interpersonal factors. One such approach, defined as 'free association narrative interviewing' (Hollway and Jefferson, 2000), starts from the position that research participants (like any person) will be defended from the things which make them most anxious in their lives. Accordingly, their defences are part of and inevitably inhibit the narrative interview. Interpretation of the free association narrative interview will attend to these 'symptomatic' elements in the pursuit of a fuller understanding of the person and his or her story.

Nonetheless, interpretative phenomenology and narrative enquiry share strong intellectual connections. While narrative psychology has developed from social constructionism (see Bruner, 1990), it also shares connections with aspects of phenomenological psychology. This is evident in the work of researchers such as Crossley, Reissman and other authors who published in the *Narrative Study of Lives* series who are interested in narrative as a mechanism for understanding life experience. These researchers primarily focus on the content of people's stories and as such make contact with interpretative phenomenological research which is interested in the use of narratives as offering experiential accounts.

To reach a decision on precisely how narrative information would be deployed in this study, I reviewed other qualitative research that examines health and illness experiences and the benefits that can be achieved from using autobiographical information as a source for interpretive phenomenological analysis. I will discuss some of this research next.

3.4 Narrative accounts of illness and recovery

Drawing upon human experience as a form of data has inherent challenges. Human experience is difficult to study as it operates in a continual process, as a “stream of experience" (James, 1890, page 229). Moreover, unlike human behaviour which is observable to others, data related to human experience relies on the ability of the narrator to reflect upon aspects of lived experience and be able to communicate these using the symbolic representation of language. The interaction between human experience and descriptions of it remains a contested philosophical issue (Devitt and Sterelny, 1987), ranging, for example, from Husserl's proposition that experience precedes language to Derrida's postmodern position that experience itself is a construction of the language one speaks. Ricoeur (1977; 1984) has helpfully offered an integration suggesting that human experience is too complex to be accurately expressed in literal language. The use of figurative expressions such as metaphors and narratives are useful as expressions which aim to expand the meaning contained in literal language and relate more closely to experienced meanings.

Notwithstanding these challenges, there has been a developing interest in narratives of the experience of illness and a growing number of clinicians and researchers focused on the use and function of illness narratives (Mishler, 1984; Cassell, 1985; Kleinman, 1989; Mishler et al, 1989; Clark and Mishler, 1992; Frank, 1995; Hyden, 1997; Mattingly, 1998; Bell, 2000; Mattingly and Garro, 2000; Charon and Montello, 2002).

There are various assumptions made about narratives, what they are and what they represent. They can be viewed as a naïve account of events, a source of subjective truth, intrinsically fictional or a mode of explanation (Paley and Gail, 2005). While for some, the subject's account in narrative research is frequently taken as authoritative (Dunniece and Slevin, 2000; Frid et al, 2000), narratives can also be viewed in terms of "what it means to be the teller of the tale” (Blumenfeld-Jones, 1995, page 26), representing the "truth of personal experience" (Sakalys, 2000, page 43). In such a context narratives do not provide access to *how it really was*, but rather *how it seemed* to the individual, at a

particular time (Leight, 2002). The important issue is the meanings and perceptions involved, not the quest to find an absolute truth (Launer, 2002; Bailey and Tilley, 2002).

It is also important to clarify what is meant by the term "narrative" and "storytelling" as they are often used interchangeably, although they can helpfully be distinguished. Paley and Gail (2005) suggested:

> the term 'story' is an interweaving of plot and character, whose organisation is designed to elicit certain emotional responses from the reader. 'Narrative' on the other hand refers to the sequence of events and the (claimed) causal connections between them (page 91).

Narrative is the rehearsal of a sequence of events causally connected; it is, as it were, generic. The authors also said:

> Story is a specific form of narrative which takes the causal sequence of events, and organises it in such as way as to construct a plot, with a central character, a problem, an explanation, and an intended reaction" (page 90).

Velleman (2003) described the link between the story's structure and the emotional cadence to which it gives rise. Therefore a story "enables its audience to assimilate events, not to familiar patterns of *how things happen,* but rather to familiar patterns of *how things feel"* (page 19). This affords two levels of explanation and accordingly two levels of interpretation: the causal and the emotional, the objective or representational and the subjective or affective.

These can be very useful in helping to understand the sense that people make about difficult life experiences, such as developing a significant mental health difficulty. From the perspective of understanding the sense that sufferers' make of developing anorexia, the aim of exploring causality within narratives may be less concerned with establishing generalisable truths about what causes anorexia *per se*, but is more concerned with establishing specific and subjective truths about why sufferer's perceive it happened to them, in a given place, at a particular time.

Such accounts will inevitably be constructed and symbolic. As Denzin and Lincoln (1998) suggested:

> Any gaze is always filtered through the lens of language, gender, social class, race and ethnicity. Subjects or individuals are seldom able to give full explanations of their actions or intentions; all they can offer are accounts, or stories, about what they did and why (page 12).

In other words, such accounts are essentially idiographic.

From my own perspective, as well as learning more about the lived experience of anorexia, the other most valuable and essential purpose of exploring narrative accounts of people who have personal experience of anorexia is that through the interpretive process, narratives offer a medium to promote empathy. This is significant in a number of ways.

Mindful of the current lack of certainty and consensus in the literature, the ability to empathise with sufferers of anorexia by entering into that person's subjective experience, *as if* you were that person (Rogers, 1968) allows clinicians and researchers to get closer to the lived experience of it. As Schwandt (2001) stated about inquiry into human experience, "it is the *life-world* as it is lived, felt, undergone, made sense of, and accomplished by human beings that is the object of study" (page 84).

As was the aim of the imagination exercise as the beginning of Chapter One, in order to better understand a topic, it is useful to be moved to feel things about it as well as think things. By bringing clinicians and researchers closer to the experience of sufferers, narratives can help explore otherness. In seeking to experience something of the sufferer's experience, a narrative approach can help reveal worlds that are otherwise closed to us. Deploying the power of empathic inquiry through listening to illness narratives also promotes equality of understandings and the possibility of meaningful partnership by working through the negotiation and sense-making that can occur between the teller and the reader/listener. Swartz (1987) suggested that part of the function of any clinical interchange between a clinician, for example a psychotherapist and a client, or a researcher and participant is to negotiate models of understanding the presenting problem (Eisenberg and Kleinman, 1981; Helman, 1985). This is made possible by the use of empathy as a means of negotiating a shared understanding. Furthermore, the research relationship can provide a fertile ground for such negotiation.

Given the current lack of clarity and lack of consensus in the literature, I would suggest that much can be learned from a methodology informed by narrative information. As Polkinghorne (1984) argued:

> Storytelling offers greatest added value where the human experience of illness is unknown or unexplored, and where clinical reality is characterised by complexity, uncertainty, and the need for integration (page 819).

Finally, I would suggest that the conduct of empathic inquiry in research promotes greater human care and compassion. Any intervention which enables people with illnesses to be experienced as subjects rather than objects, as people 'like me' than the carriers of a disease, 'not like me', means that those responsible for treating and supporting sufferers do so with 'hearts and minds'.

In summary the value of narratives about illness is that they provide information about what is personally meaningful, contextualised, relational, inductive, evocative, pluralistic, imaginative, lateral, amusing, private, intimate, humanistic, individualistic, constructed, performative, symbolic and practical (Roberts, 2000). It is these qualities which make personal stories a rich and useful way of expressing and understanding human experiences of illness and recovery. As previously stated, interpretative phenomenology seeks to explore both the ways in which people describe their personal experiences to themselves and others as well as the ways people create meaning about their experiences and those of other people. So far, I have discussed the potential benefits of narrative accounts as a helpful way to collect data about individual's subjective experiences. At this point, it is important to discuss issues related to the interpretation of such narrative data - in this case, how I might undertake a process of sense-making about participants' experiences of developing anorexia, recovery and the role of psychotherapy based on what they tell me about those experiences.

Designing an appropriate research methodology which draws upon experiential information as data requires consideration of the ways in which meanings are both constructed and co-constructed and involves the concept of the 'double hermeneutic' (Smith and Osbourn, 2008). This relates to the ways in which the researcher makes sense of the participant, who in turn is making sense of their own subjective experience.

In this context, the participant who is accessing their own experiences might be said to be offering first order meaning-making, while the researcher's sense-making is second order. This requires attention to the propositions of Gadamer and Schleiermacher, which emphasised the relevance of the author in any interpretive activity and the context in which such human experience descriptions are acquired. For example, within a research context, the co-construction of meanings may be based on the questions the interviewee is asked about their experience, spanning open-ended questions to facilitate greater narrative leadership from the storyteller, through to highly structured questions, such as those employed in survey-based research or those employing quantitative analysis to narratives (for example, see Dale and Davies, 1994; Yumaguchi, 1991).

In addition, the co-construction of meanings occurs within the "conversational space" (Elliott, 2005, page 10) between researcher and participant. For a period, the conversational space requires the participant/narrator to take a lead while the researcher/listener hears the story (Coates, 1996; Sacks and Jefferson, 1992). However, this shifts to allow the researcher/listener the opportunity to contribute to the conversation through "mutual reformulation" (Mishler, 1986, page 53) of the questions being explored and the process of negotiating a shared meaning. As Elliott (2005) described:

> while the speaker can be understood as responsible for producing a narrative with an acceptable evaluation, the addressee or audience must collaborate by demonstrating that the evaluation has been understood (page 9).

These important issues pertaining to the co-construction of meaning further influenced more detailed decisions about the methodological design of the study, which will be discussed later in this chapter.

3.5 Introducing phenomenological objectives

3.5(1) Implementing an in depth narrative methodology

Given the influential relationship between the data generated in qualitative research, the questions asked and the context in which data is gathered, a further decision had to be

made about the context in which these questions would be asked and the structure of the questions posed to participants. I will discuss each of these in turn.

Although researchers have a variety of data collection methods at their disposal including postal questionnaires (Coyle and Rafalin, 2001), electronic e-mail dialogue (Turner et al, 2002), group meetings (Flowers et al, 2001; Roose and John, 2003) and observational methods (Larkins and Griffiths, 2002), research which aims to elicit subjective narrative information often deploy the use of research interviews (Elliott, 2005; Smith, 1993; Plummer, 2001). The use of interviews to acquire information is so widely used in contemporary society, it has been said we live in an "interview society" (Atkinson and Silverman, 1997; Silverman, 1993). Not only are they used to examine the activities of people's lives, they also engage with issues such as the ways in which people construct order about their life and create meaning about what is important (Cicourel, 1964; Gubrium and Holstein, 1997; Kvale, 1996; Sarup and Raja, 1996; Seidman, 1991; Silverman, 1993; 1997).

Interviews can be arranged and implemented in a number of ways but generally involve an interpersonal interaction and exchange between the researcher and participant and are often designed as face-to-face meetings, either in groups or with individual participants. The aim of the interview is largely to facilitate an interpersonal interaction which supports participants to share experiences, in their own words. This involves talking and listening for both participant and researcher, although it is clearly important that the former has more opportunity to share subjective experience.

Reid et al (2005) proposed that one-to-one interviews are an effective and often preferred method of collecting such data. In seeking to interpret phenomenology, accessing personal narratives via interview is a potentially rich and effective way of doing so. They suggested that the main advantages of the individual interview is that it is relatively easy to manage and allows for the development of interpersonal rapport, giving participants the time and space to think, feel, speak and be heard.

The use of interviews to collect data also presents particular challenges. This relates to the contention that narratives are intrinsically fictional. This idea goes back to Sartre's (1965) suggestion that there are no 'true stories', a position that challenges Husserl's

notion of discovering essence within human experience. More recently, authors such as Langellier and Peterson (2006) discussed the process of storytelling (which includes narrative-based research interviews) in terms of *performance*. This involves the idea that a story comes from a 'self' with a past, who seeks to involve, influence and perhaps even move the present or future audience. It speaks of how the teller of the story wishes to be *known*, which inevitably means that some of what is said may be false, untrue or misremembered (Reissman, 2003; 2005). For a participant in this study, this might include what they imagine I want to hear as researcher, what the examiners of this thesis might want to see or read, or indeed how they wish to be understood by a wider audience, including other sufferers, carers or people working in the helping professions. In my view, this does not negate the importance or potential value of narratives as data. While they might not offer an unchanging reflection of what occurred to the participant, both the content of the narrative and the way it is told, offer valuable insights into the narrator's beliefs, perceptions, and understandings of their experience. This is precisely what this study seeks to explore. As Kelly and Dickinson (1997) suggested: "the narrative self produces and sustains meanings that are inter-subjectively shared. Thus the narrative is orderly and so is self" (page 276).

In addition, narratives about the role of psychotherapy reflect layers of interpretation and meaning-making. This includes the sufferer's initial storied account as shared with their therapist, their therapist's interpretation of that account, before moving onto the co-construction of new and differing meanings, *to 're-story'* as part of the psychotherapy process. In turn this affords the opportunity to create a new narrative that is frequently powerful, meaningful and well rehearsed by the recipient of psychotherapy. Therefore storied accounts of psychotherapy offer rich and valuable information about the things that make psychotherapy therapeutic.

Therefore, given the subject matter of this research, I was drawn in principle to the use of narrative interviews and specifically individual face-to-face interview meetings, which I hoped would provide a relaxed, private and secure interpersonal environment conducive to hearing directly from and learning more about anorexia from people with subjective expertise. Furthermore, not only would face-to-face interviews allow me to hear the content of participants' personal experience but make use of important process

issues, such as the non-verbal characteristics of the interview and the impact of the research relationship on data collection.

Having reached a decision to utilise face-to-face research interviews, I returned to the issue of what participants should be asked – for example, whether to elicit purposeful conversations deploying an unstructured in-depth interview, or a semi-structured interview that created more guidance to participants' narrative process. Although interpretive phenomenology sees the participant as an experiential expert on the topic at hand and therefore encourages the researcher to give the participant "much leeway in taking the interview to 'the thing itself'" (Smith et al, 2009, page 58), the use of interview schedules can be helpful to prepare the content of the interview, to provide a flexible structure to manage the interview process and to plan for difficulties that might be encountered, such as participant anxiety, dilemmas about disclosure, getting off topic and drifting out of the research activity (Kahn and Cannel, 1967)

Given my objective to gather subjective accounts of a number of *specific* areas, namely developing anorexia, recovery and the role of psychotherapy in recovery, I elected to construct a semi-structured individual interview to facilitate an interaction that promoted the generation of detailed accounts of each of these particular areas of inquiry. However, constructing a schedule for a semi-structured interview required careful planning. Researchers are cautioned to avoid a focus that is overly centred on their research aims, to the detriment of participant's aims (Hollway and Jefferson, 2000). Shinebourne and Smith (2010) also discouraged simply asking the participants the broad research questions. Instead, they encouraged the researcher to think about the range of topics to be covered, the ordering of questions, and the phrasing of questions. They also suggested discussing or trialling the questions with a potential participant, with colleagues or supervisors.

3.5(2) The use of a focus group

The interview schedule was constructed and piloted using a focus group with potential participants to explore if the questions would generate the quality of information sought. The hallmark of focus groups is "the explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group"

(Morgan, 1988, page 12). There are some studies which have deployed focus groups in interpretive phenomenological work (Flowers et al, 2001; Roose and John, 2003). However the application of experiential analysis to more complex social system activities, such as group-based activities, is complex and can be problematic. Smith et al (2009) suggested, "the presence of multiple voices, and the interactional complexity of such events does make it more difficult to enter and develop the phenomenological aspects" (page 71).

Nonetheless, given the strengths of focus groups to pre-test research questions (Frey and Fontana, 1991), I decided to undertake a focus group to allow me to enter into the role of researcher and use a group interaction to experience whether participants would begin to engage in a research dialogue with me, to refine the interview schedule and assess the utility of group as well as individual interviews.

The focus group proved to be very useful in socialising me to the role of researcher and in refining the interview schedule. I concluded that individual interviews were my preferred method to generate narrative data.

I will now discuss the development of the interview schedule and associated activities in more detail describing the individual interview schedule (*3.5(4)*), planning and coordination of the face-to-face interviews (*3.6-3.7*), and the focus group (*3.8(2)*) and individual interviews in practice (*3.8(*1*)*).

3.5(3) The interview schedule: A semi-structured conversational space

Following the focus group, the semi-structured individual interview schedule was devised and is offered as Appendix 1. Questions were deliberately open and expansive, yet sub-questions were created under each of the main headings. These were employed as prompts to encourage and support participants to offer more detailed information when required. The semi-structured individual interview was divided into three main parts.

During the first part, participants were asked to discuss what happened when they developed anorexia. When required, I included prompt questions to elucidate contextual

information, for example, age at diagnosis, context the diagnosis was given within as well as information on the participant's own reaction and the reaction of significant others. Participants were also asked for their views on factors that may have triggered their illness as well as ideas on what may have caused their eating disorder. Although the study was aimed at exploring accounts of people who had recovered from anorexia, in order to contribute to understandings of the role of psychotherapy in recovery, I believe it is essential to include participants' accounts of developing anorexia. It would have been difficult to develop coherent and meaningful experiential accounts of recovery, without situating these within experiential accounts of the illness.

During the second part of the interview, participants were asked what had helped them with recovery. This was a fundamental question and I wanted to find a way of allowing participants to fully reflect on and express this. I also wanted to maximise opportunities for me, as researcher, to get close to the participants' expressions and understandings of their lived experience of recovery. The use of visual aids, such as drawings and other diagrammatical representations are regularly deployed in research with children (Golomb, 2002; Rabin and Haworth, 1960) and in some types of research with adults, such as those exploring creative therapies (Clark-Keefe and Kelly, 2009). Such visual methodologies are considered to be a means of communicating perception and are products of thinking, not simply representations on paper (Thomas and Silk, 1990). As a result, participants were asked to complete a Recovery Chart, which asked them to define the various important factors that contributed to their recovery. Participants were also invited to visually represent the relative contribution of each of these factors by dividing their chart into sections and giving it a percentage value if the participant chose to. A copy of a blank Recovery Chart is illustrated as Appendix 2. The completed Recovery Charts can be found in Chapter Five.

During the final part of the interview, participants were asked to explore the role of psychotherapy in their recovery from anorexia. Participants were asked if they thought it had aided their recovery. They were invited to explain how they believe it worked, what was most helpful, what aspect made the biggest difference, and if there are aspects of their psychotherapy that participants' continue to use to sustain their recovery. In the majority of interviews, information was volunteered spontaneously within participants'

subjective accounts of 'what happened'. However, in some interviews, information was generated through a more interactive conversation.

3.6 Recruitment Strategy

3.6(1) Accessing potential participants

The value of data obtained by qualitative methods is contingent upon the selection of an adequate and appropriate sample. My aim was to recruit volunteers who had an interest in sharing their personal experience of developing anorexia, of recovering from it and the role that psychotherapy played in their recovery process. Accordingly, I needed to establish a sampling strategy that is consistent with a qualitative research paradigm and in particular, one which is committed to the exploration of lived experience and the ways people generate meanings about significant occurrences, such as developing and recovering from a serious illness. I wanted to access potential participants for whom the research questions would have relevance - people who had something to say and wanted to talk about their lived experience with anorexia. This required recruitment of a relatively homogenous sample, in other words, people who have a history of suffering from anorexia, have made a recovery and who have received psychotherapy as part of their treatment.

The issue of homogeneity involved both interpretative and practical considerations. Interpretative considerations included attention to the ways in which potential participants might vary from each other and how much variation could be contained within the sample. Firstly, my research sample needed to be able to generate data that would meaningfully respond to my research questions. Had I wanted to explore the experience of adolescents who had recovered from anorexia, I would have created an age category in the inclusion criteria. Had I wanted to explore the role of a particular model of psychotherapy, I would have selected people who had experience of this specific psychotherapeutic modality. However, the emphasis of this study is to examine the experiences of people who had been offered a range of models of psychotherapy across Scotland and to explore commonality and difference in their subjective accounts. As a result, a key sampling priority was to seek to recruit people from different parts of

Scotland, with experience of a range of different models of therapy, delivered in a range of settings. In addition, given the limited number of facilities dedicated to the provision of eating disorder treatment, I was concerned that if I limited the geographical boundary of the sample to one or two areas in Scotland, I would effectively be exploring the treatment of one or two treatment establishments and as a result, the psychotherapeutic interventions of a very small number of clinicians.

Secondly, given the potentially sensitive nature of the issues being examined in this study, I decided to select participants who were over the age of 18 years. I hoped this would ensure that it was developmentally and psychologically appropriate for all participants to engage with the matters being explored in this study. This decision also contributed to increased sample homogeneity in that all participants were adults at the time of participating in the study, albeit that the age of onset of anorexia ranged from 13 to 19 years.

Thirdly, an exploration of lived experience and the ways people make meaning about their experiences requires a commitment to engage with the richness, diversity and complexity involved in living. It also requires a basic respect for the individual case, for example, what does the lived experience of anorexia feel like and mean for this person? While some research methodologies select a sample with the aim of generating findings which are empirically generalisable, my aim was to explore each individual case in its own right and in doing so explore areas of convergence and divergence across the sample. As a result, I decided not to impose further uniforming conditions on the sample, such as stipulating particular social or theoretical factors.

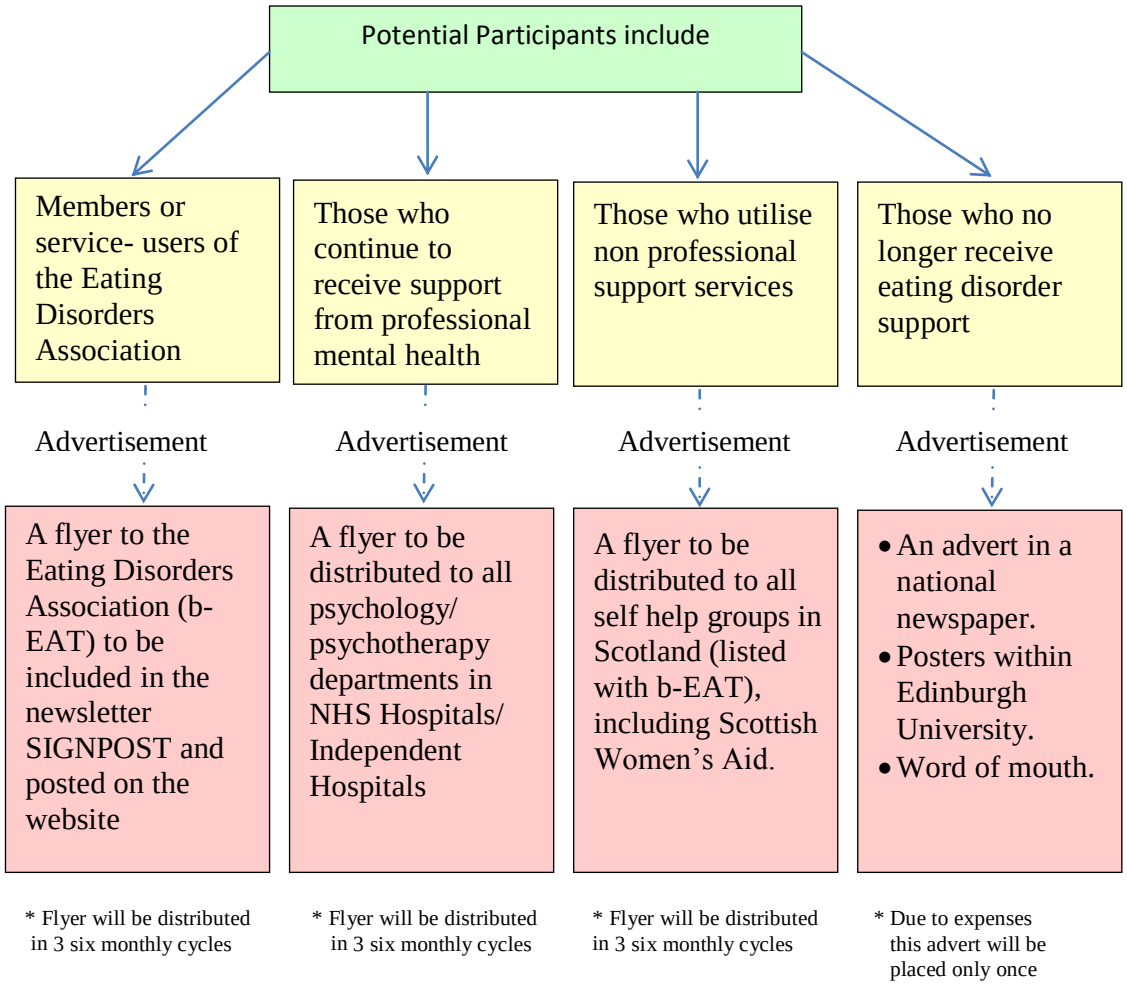
Fourthly, given the idiographic nature of the study, with a focus on the 'particular', I wanted to keep the sample size to a number that would allow for detailed and in-depth exploration of the personal accounts collated. There is no definitive answer to the question of sample size in interpretive phenomenological research. Smith et al (2009) suggested a rough guide for doctorate level research between four to ten interviews. However, they stressed that higher participant numbers is not indicative of the overall quality of the study, which ultimately seeks to explore human experience in depth.

Practical considerations involved identifying which people have such lived experiences and how they could best be contacted. Potential participants were accessed using two main strategies. The first was by generating 'referrals', from a range of gatekeepers, which included some gatekeepers directly linked to eating disorder treatment and some who were not. My rationale for this was that some people who have recovered from anorexia may continue to maintain contact with professionals who were involved in their care or may have agreed that the treatment centre can retain their contact details for research purposes. This informed my decision to advertise through all clinical settings that deliver eating disorder treatment in Scotland. Conversely, other people may have disengaged from their treatment establishments completely. Therefore, I decided to advertise using a variety of non-clinical sources, including the national eating disorders charity, b-EAT, the University of Edinburgh, the Head Offices of Scottish Women's Aid and a newspaper.

The second was by generating 'opportunities', by making contact with people who had maintained links with my place of work and with colleagues who were willing to share information about the study with their own personal and professional networks. My supervisors also shared their knowledge of the study with people whom they thought might wish to take part and would meet the inclusion criteria. I also hoped that new participants might be accessed via 'snowballing' in which participants themselves generate new referrals to the research. However, this did not happen during the course of the study. While the precise reason for this is unknown, I have reflected that the sensitive and confidential nature of the material that participants shared during their engagement with this research may have resulted in an understandable wish to preserve a degree of privacy about their involvement with it.

Issues related to participant identification, approach, and recruitment were discussed in regular PhD supervision with both research supervisors. I also sought advice from the research committee based at my place of work. The participant access and recruitment strategy took a multiple source approach. This is illustrated diagrammatically in Figure 1:

Figure 1: Participant identification and recruitment



Information about the study was sent to and disseminated by the national eating disorders charity b-EAT (at the time, known as the Eating Disorders Association), all NHS and independent sector hospitals/treatment centres in Scotland, a number of self-help groups across Scotland and an advertisement in a local newspaper serving an area in the west of Scotland. Information posters were also posted throughout the University of Edinburgh in various campus sites and in the Head Offices of Scottish Women's Aid in Edinburgh and Glasgow. From each of these sources, information was disseminated in the following ways:

- b-EAT: an advertisement was posted on the website and an email sent to their list of members who had declared an interest in research participation;

- NHS/Independent hospitals and treatment centres: an advertisement flyer was sent to each hospital clinic, following approval by the treatment centre's lead clinician;
- Self-help groups: an advertisement flyer was sent to each self-help group listed on the b-EAT and Scottish Eating Disorders Interest Group's websites;
- A newspaper advertisement in the *Hamilton Advertiser*: this was intended to recruit participants who were no longer engaged with support services. I also wanted to specifically generate more participation from the west of Scotland.
- University of Edinburgh: Information posters were displayed publicly across a number of campus sites, and
- Women's Aid: an advertisement flyer was sent the main offices in Glasgow and Edinburgh.

The advertisement flyer sent to each of these organisations/groups is provided in Appendix 3.

The timing of recruitment and specifically the time between responding to an initial enquiry and conducting the focus group, and/or individual interview was important. The study was being undertaken on a part-time basis. Therefore, I staggered recruitment to ensure I was able to meet participants promptly after they responded to the advert. I adopted a phased approach to recruitment over an eighteen month period between January 2007 and June 2008. This involved recruiting in January 2007, June 2007 and finally in January 2008.

The recruitment strategy generated 18 initial enquiries in total. From these initial enquiries 12 participants were recruited to take part in the study. During phase one, I recruited 5 participants. In phase two, I recruited 4 participants. In phase three, I recruited 3 participants. Table 5 illustrates the sources of these enquiries and numbers eventually recruited into the study.

Table 5: Outcomes of enquiries by potential participants

Recruitment Source	Number of enquiries	Outcome of enquiries
b-EAT	7	3 recruited into the study. 4 based in England/did not meet inclusion criteria
University website/flyers	3	All recruited into the study
Word of mouth (3 via clinicians/1 via Supervisor).	4	All recruited into the study
Ex patient from researcher's workplace	2	1 recruited, 1 did not meet inclusion Criteria
SEDIG	1	Potential participant chose not to take part
Newspaper Advertisement	1	1 recruited

3.6(2) Introducing the study to potential participants

Participants made initial contact either using the email address or the mobile telephone number provided. During the initial telephone consultation, I explained the aims of the study and the main tasks involved. This included meeting the participant for two face-to-face meetings at a mutually convenient time and location. I explained that the first meeting would provide an opportunity to explain the study in more details, answer any questions and establish if the potential participant met the inclusion criteria by administering the Eating Disorder Examination. Inclusion criteria are discussed next in *3.6(3)*. I then explained that the second meeting would involve undertaking a semi-structured individual interview. I mentioned that I could meet participants on a further occasion either to complete the individual interview if more time was required, or if the participant wished to discuss anything related to taking part. Participants recruited in the

first phase of the study were also given information about the focus group during their initial meeting and given the opportunity to participate in it. Five participants took part in the focus group, all of whom went on to take part in an individual interview. One participant opted not to participate in the focus group but agreed to participate in the individual interview. A copy of the participant information leaflet was also given to all potential participants. A copy of the participant information leaflet is provided as Appendix 4.

3.6(3) Selection criteria

For the protection of participants, a number of inclusion and exclusion criteria operated during the recruitment phase. The principal inclusion criteria were women and men aged 18 years and over. Participants had to have received a diagnosis of anorexia nervosa in the past and have received psychotherapy, either on an inpatient or outpatient basis, as part of their treatment. To fulfil diagnostic criteria for anorexia nervosa, there are key features that need to be present in the preceding three months, which span physical, psychological and behavioural indices.

These include:

1. Over-evaluation of shape and weight and their control; that is judging self- worth largely, or even exclusively, in terms of shape and weight and the ability to control them.
2. Active maintenance of an unduly low body weight (typically defined as maintaining a body weight less than 85% of that expected or a body mass index of 17.5 or below).
3. Amenorrhea (in post-pubertal females).

Before participants were formally recruited to this investigation, an Eating Disorder Examination, (EDE) (Cooper and Fairburn, 1987) was undertaken. The EDE is a semi-structured interview for the assessment of specific detail, referred to as the 'psychopathology' of eating disorders and is able to identify if the interviewee continues to meet diagnostic criteria. It is intended to assess the full range of psychological disturbance, including dietary restriction patterns, eating, and weight and shape

concerns. The EDE is designed to assess the present state of the interviewee and is concerned with the preceding 3 months.

Given that the primary research question is aimed at eliciting further information and understandings about recovery and the role of psychotherapy, coupled with the difficulties within current literature associated with multiple definitions of and thresholds for recovery, I believed it was important to set a fairly high threshold for recovery that covered physical, psychological and behavioural indices. Although all psychometric measures have limitations, the EDE is a useful tool in measuring existing eating disorder difficulty as it allows respondents' scores to be assessed against norms for people with existing eating disorders (anorexia and bulimia nervosa), dieters and healthy controls.

The main finding from the EDEs was slightly elevated subscale scores for weight and shape concerns, with lower scores for dietary restraint and eating concerns. My interpretation of this data is that dietary restraint and eating concerns are more behaviourally-focused questions. For example, a question from the restraint subscale is, 'Over the last four weeks/ three months have you been consciously trying to restrict (cut back) the overall amount that you eat, whether or not you have succeeded?; a question from the eating concern subscale is, 'Over the past four weeks/three months have you been concerned about other people seeing you eat and has this concern led you to avoid such occasions? Participants reported that their day-to-day routines around food and eating were *not* significantly impaired. Nonetheless, most participants continued to experience some weight and shape concerns. For example when questioned about weight, most participants commented that they continued to experience some dissatisfaction with their weight, or had some sensitivity to weight gain. In addition, some participants continue to experience a level of dissatisfaction with shape or maintain a degree of vigilance about their body shape. However, based on their responses, participants did not to allow these concerns to significantly affect their behaviour; for example, such concerns did not lead to weight loss strategies or compensatory behaviours after eating. A meta-summary of the Eating Disorder Examinations is offered in Appendix 5.

The EDE also examined the participant's current weight. To be outside the weight range for anorexia, participants had to have a Body Mass Index in the range of 17.5-24.9. The

BMI range of participants can also be found in Appendix 6 and illustrates that all were significantly above a BMI of 17.5.

For the welfare of participants and to best achieve the aims of the study, a number of exclusion criteria were adopted. Exclusion criteria included young people under the age of 18 years and individuals who continue to meet diagnostic criteria for anorexia nervosa, using the EDE, during the recruitment phase. In addition, it was agreed that individuals subject to compulsory measures of care under the Mental Health (Care and Treatment) (Scotland) Act 2003 would require supporting evidence from their Responsible Medical Officer to confirm the potential participant's capacity to make an informed decision to consent. The issue of consent is discussed more fully in *3.7(4).* None of the participants recruited to the study were subject to compulsory measures of care at any point during their involvement in the research.

3.6(4) The research sample

The need to protect participant identities was an essential ethical and practical concern throughout the entire process of undertaking the study and in selecting how to present my findings. Given the selective nature of the sample, I was aware of a risk that I might present participants in a way that would inadvertently offer identifiable information. For example, by placing a particular person (including their gender and age) with a particular geographical area where they received psychotherapy, or even with a particular type of therapy, I was aware that this information could potentially allow certain readers to trace back to the actual participant. Having a single male participant in the study brought this issue into sharp focus. There are so few males in Scotland who access specialist treatment for anorexia, it was more challenging to establish how to preserve his anonymity. This concern necessarily informs the amount of information I will provide about each participant and the way that I present participant information throughout the entire thesis. This includes my decision not to include a full description of the characteristics and experiences of each person in the sample in any one place within the thesis.

A total of twelve people participated in this study over the eighteen month recruitment period. An overview of the sample is provided as Table 6 which introduces the reader to

the participants who generously agreed to take part. Participants' names are pseudonyms which have been used to protect their identities.

Table 6: Research participants

Name / pseudonym	**Participant information**
Craig	Craig is a 19 year old man with a 2 year history of anorexia nervosa. He was diagnosed with anorexia nervosa aged 17 years, and following treatment has now recovered. At the screening interview for participation in the study, his weight was 70 Kg, height1.65 m, BMI: 25. He lives with his parents, is in full-time employment and enjoys an active social life, including spending time with his girlfriend and playing sports.
Nadia	Nadia is a 28 year old woman who was diagnosed with anorexia when she was 16 years old. Following treatment, she reports recovering in her mid 20's. At the screening interview for participation in the study, her weight was 53 Kg, height1.60 m, BMI: 20.5. She lives with her fiancé and is currently in her final year of a full-time degree course.
Rosie	Rosie is a 24 year old woman who was diagnosed with anorexia nervosa aged 13 years. Following treatment, she reports recovering at the age of 20 years. At the screening interview for participation in the study, her weight was 55 Kg, height 1.57m, BMI: 22. She lives in a flat-share with a group of friends and is in her third year of a full-time degree course. She enjoys an active social life and is busy with student placements.
Kate	Kate is a 20 year old woman who was diagnosed with anorexia nervosa aged 14 years old. Following treatment she reports recovering from anorexia when she was 18 years. At the screening interview for participation in the study, her weight was 60Kg, height 1.67m, BMI: 21.4. She lives in a flat-share with a group of friends and is in her second year of a full-time degree course. She visits her parents regularly at weekends.
Emily	Emily is a 48 year old woman who was diagnosed with anorexia nervosa aged 18 years old. Following treatment she reports recovering from anorexia at approximately 28 years. At the screening interview for participation in the study, her weight was 54Kg, height 1.66m, BMI: 19.6. She lives with her son and daughter, having divorced in the last 5 years. She works in a highly skilled profession.

Janice	Janice is a 52 year old woman who was diagnosed with anorexia nervosa aged 17 years old. Following treatment she reports recovering from anorexia in her mid to late 20's. At the screening interview for participation in the study, her weight was 58Kg, height 1.72m, BMI: 19.6. She lives with her husband and has adult children. She works in a highly skilled profession.
Pamela	Pamela is a 30 year old woman who was diagnosed with anorexia nervosa aged 16 years old. Following treatment she reports recovering and being well for 10 years before briefly relapsing aged 27 years. She has been well again for approximately 2 years. At the screening interview for participation in the study, her weight was 64Kg, height 1.71m, BMI: 21.9. Pamela works in a highly skilled profession. She is recently separated from a long term partner.
Anna	Anna is a 29 year old woman, with a 4 year history of anorexia nervosa. She was diagnosed with anorexia nervosa aged 19 years, and following treatment, reports that recovery took approximately 4 years. At the screening interview for participation in the study, her weight was 55Kg, height 1.51m, BMI: 24.1. She lives with her fiancé and her young children. She is currently seeking paid employment in the area of eating disorder treatment.
Leah	Leah is a 41 year old woman with a 2-3 year history of anorexia nervosa. She was diagnosed with anorexia nervosa aged 17, and following treatment, reports that recovery has been an ongoing process. She was free from the most severe symptoms by 20-21 years of age. At the screening interview for participation in the study, her weight was 57Kg, height 1.60m, BMI: 22.3. She lives with her two teenage children and is divorced. She is currently seeking paid employment.
Bethany	Bethany is a 26 year old woman with a year 1-2 history of anorexia nervosa, although she has experienced episodes of disordered eating spanning approximately 14 years. She was diagnosed with anorexia nervosa aged 18 years, and following treatment, reports that recovery took place in her early twenties. At the screening interview for participation in the study, her weight was 54Kg, height 1.64m, BMI: 20.1. She lives with her partner and is in her final year of a full-time degree course.
Caitlin	Caitlin is a 21 year old woman with an 18 month history of anorexia nervosa. She was diagnosed with anorexia nervosa aged 17 years, and following treatment, reports that recovery took a further year. At the screening interview for participation in the study, her weight was 50Kg, height 1.62m, BMI: 19.1. She lives with friends and is completing a full-time degree course.

Ailsa	Ailsa is a 39 year old woman with a year long history of anorexia nervosa, followed by a history of bulimia nervosa spanning from 17 years until her mid-twenties. She was diagnosed with anorexia nervosa aged 11, and reports that she recovered from her eating disorders after receiving treatment in her twenties. At the screening interview for participation in the study, her weight was 55 Kg, height 1.50m, BMI: 24.4. She lives with her husband and two young children and works on a part-time basis.

The twelve participants consisted of eleven women and one man aged between 19 and 52 years. Eleven spoke English as their first language and one spoke Spanish, although she is fluent in English. All participants had received a diagnosis of Anorexia Nervosa, eight with binge/purge subtype and four with restrictive subtype. However, participants' accounts conveyed how their eating disorders changed over time, with some moving between restrictive and binge/purge behaviours. This reflected Fairburn's observation of a more fluid change of symptoms over time, discussed in Chapter Two. Some participants had received another diagnosis. Four had been diagnosed with Depression and two with an Anxiety disorder. One participant had been given a diagnosis of Borderline Personality Disorder. Participants' experience of anorexia differed in longevity with the shortest duration of illness cited as 2 years, and the longest exceeding 10 years. The length of time participants had been recovered also varied considerably. For example, some of the younger participants had recovered in the last few years, with the most recent recovery identified as occurring one year prior to the individual interview. The older participants had sustained longer periods of recovery, with the longest exceeding 20 years. In terms of social functioning, all participants were either working or studying full time. All reported a strong social network, including significant relationships with partners, spouses, friends, children, and parents and extended family members.

Participants had received a range of treatments. This information is provided in Table 7.

Table 7: Participants' experiences of individual psychotherapy

Model of Psychotherapy	Profession of therapist	Treatment context	Frequency	Duration
Cognitive Behavioural Therapy	Clinical Psychologist	Hospital based (inpatient)	Weekly	8 months
Cognitive Behavioural Therapy	Clinical Psychologist	Hospital based (day patient)	Weekly	10 months
Unknown by participant	Clinical Psychologist	Hospital based (outpatient)	Weekly	20 months
Unknown by participant	Clinical psychologist / psychotherapist	Hospital based (day patient)	Weekly	9 months
Unknown by participant	Psychotherapist	Hospital based (inpatient)	Weekly	10 months
Unknown by participant	Psychotherapist	Hospital based (outpatient)	Weekly	26 months
Unknown by participant	Psychotherapist	Hospital based (inpatient)	Weekly	14 months
Cognitive Behavioural Therapy	Nurse therapist	Hospital based (outpatient)	Weekly	9 months
Cognitive Behavioural Therapy	Nurse therapist	Hospital based (inpatient)	Weekly	8 months
Unknown by participant	Nurse therapist	Hospital based (inpatient)	Weekly	20 months
Unknown by participant	Counsellor	Private practice	Weekly	12 months
Unknown by participant	Counsellor	Work-based counselling	Weekly	18 months

Six participants had received inpatient treatment, including refeeding for weight restoration. One participant had been detained for over a year under mental health legislation. Two had received day patient treatment and four had engaged in outpatient treatment. Ten out of the twelve in the sample had received psychotherapy as part of

their hospital-based treatment. However, two participants pursued psychotherapy independently and sometime after their hospital admission for weight restoration and stabilisation.

Participants met with a range of professionals. Three met with a clinical psychologist, three with a psychotherapist, three with a nurse therapist and two with a counsellor. One participant saw both a clinical psychologist and a psychotherapist as the same time. Four participants said they had been offered cognitive behavioural therapy, two by nurse therapists and two by clinical psychologists. The remaining participants said they were unsure of the actual model of therapy that was being offered, but were able to describe what took place within their sessions.

Two participants talked about receiving longer term, open-ended therapy which had a focus on exploring past relationships and experiences and the impact of these on the development and maintenance of their anorexia. This description made me question if they had worked with a psychodynamic practitioner as their descriptions of therapy were consistent with that.

Participants' accounts of their psychotherapy offered descriptions of a range of eclectic interventions, based on assessment and therapeutic goal-setting. These included solution-focused interventions, such as creating personal safety from abusive relationships, and/or strategies to assist with regulating eating patterns and weight restoration as well as support and guidance to make important transitions, such as leaving home, moving to a new area and/or starting an educational course. I heard descriptions of trauma-focused work, and interventions aimed at teaching psychological skills in interpersonal effectiveness, distress tolerance, emotion regulation and improving meta-cognitive awareness. A full description and discussion of the provision of psychological therapy can be found in Chapter Six.

Sessions were offered on a weekly basis, although three participants were able to contact their therapist between sessions and made use of this support. The duration of therapy varied from 8 to 26 months, with the average 18 months.

3.7 Ethical considerations

Ethical research practices are dynamic processes that require on-going monitoring throughout the entire life cycle of the study (Mishler, 1986; Reissman, 1993; Elliott, 2005). Ethical issues and dilemmas have been a major consideration in selecting an appropriate methodology and designing this study. It has involved thinking about the human care that is required from potential participants' first point of contact with this study throughout their entire involvement with it. Such is the centrality of ethical issues within this study that an exploration of them under a specific section in the thesis runs the risk of misrepresenting their embedded nature in each decision and intervention that had to be made. Nonetheless, throughout *3.7*, I will identify and discuss important ethical principles and practices that have informed the research process, before moving on to discuss the research interviews in practice. Accordingly, when discussing the interviews in practice, this is also an exploration of applied ethical practice.

An important starting point for any research is to avoid doing any harm to participants. In qualitative research aimed at exploring subjective experience of illness, there are a number of issues to be addressed. These include carefully identifying and managing any potential distress to participants, addressing any risks associated with participation and ensuring that the people who decide to take part do so on a voluntary basis, having been given as much information as possible to ensure that consent is well informed.

Lieblich (1996) compared narrative interviewing to 'opening a Pandora's box'. Describing her experience of collecting the life stories of members of the kibbutz, she suggested, "I was constantly tormented with the sense of opening up my interviewee's wounds and (as I thought then) leaving them with the pain" (page 177). However, Smith et al (2009) cautioned "one must always evaluate the extent to which simply *talking about* sensitive issues might constitute 'harm' for any particular participant group" (page 53). Smith et al suggested that talking about sensitive issues does not necessarily result in distress or harm and has to be assessed both on an individual basis and over a period of time. Furthermore, it is useful to identify the potential benefits for participants in taking part in research that explores their accounts of illness, recovery and possible curative factors. What Lieblich's statement helpfully highlights is the potential adverse

effects, risks or hazards, pain, discomfort or distress both to the participant and the researcher (Hollway and Jefferson, 2000).

3.7(1) 'Opening Pandora's box': Attending to participant distress

Mindful of the potentially distressing affects of discussing illness experience, a number of strategies were employed to attend sensitively to this issue.

Firstly, participants were recruited on the basis that they no longer met diagnostic criteria for anorexia nervosa. This decision was not only influenced by the objective of the study (to explore accounts from people who had already recovered); I was concerned that potential participants who still met diagnostic criteria may find participation particularly challenging as the issues being explored would be current and persisting difficulties for the individual.

Secondly, as part of the initial meeting with potential participants, a screening process was pursued to ensure they had a social and/or professional support network to access if they experienced discomfort or distress. None of the participants were receiving regular support from either specialist eating disorder services or generic mental health organisations. This was not surprising given that participants had achieved a particular threshold of recovery and had been discharged from those services that had previously supported them. All described their support networks to include partners/spouses, family members, friends and colleagues/fellow students. I enquired if each participant had shared their intention to participate in the study with a member of their support network and all had.

Thirdly, as well as accessing their own personal support networks, participants were given the opportunity to meet with me after the individual interview to discuss any issues related to participation in the study. None of the participants utilised this support, although one potential participant decided after our initial meeting that she did not feel sufficiently secure in her own recovery to participate. We talked at length on the telephone and explored a discussion she had with her husband on the issue. Although this potential participant met the inclusion criteria for participation, she reported difficulties with food and eating in the few weeks prior to our discussion. Having been

on summer holiday, she perceived the change in routine had triggered a phase of dietary restriction and some limited weight loss. We agreed that I would contact her a few months later to ascertain if she felt in a better position to participate. She declined this offer at follow-up. This reinforced the importance of taking time to fully discuss participation during the initial meeting.

Sharing the questions that would be explored during the individual interview and seeking to identify what might trigger distress allowed the participants and I to work collaboratively to remedy possible challenges and generate problem-solving strategies at an early stage. For example, one potential participant anticipated that the individual interview might "stir things up" and we deliberately arranged to meet on a day of the week when she did not have lectures the next day, allowing her time for further self-reflection at home. She identified this as her preferred strategy to promote self-care.

Finally, I adopted a proactive approach with participants about the potential risk of relapse. At the recruitment stage, participants were asked to share contact details of their GP. We agreed that if they experienced a relapse of their eating disorder during their involvement in this study, specifically to the degree that their health and/or safety was at risk, I would have permission to discuss this with their GP, or find another way of supporting the participant to share this information with their GP. This approach relied upon the participant or member of their support network initiating contact with me. It is important to emphasise that this aspect of participant-preparation was framed in a way to reinforce both that these risks were unlikely and that any risks associated with participation needed to be balanced against possible benefits to participants. As previously mentioned, by examining the ways in which psychotherapy assisted participants in their recovery from anorexia, each had the opportunity to reflect upon and share information related to their recovery process. The potential benefits included meeting other people who had been through a similar process, potentially offering mutual support and the mitigation of isolation. Moreover, the opportunity to talk about recovery and share recovery stories may have had the potential benefit of strengthening participants' association with recovery and act as a relapse prevention strategy.

Having explored potential risks and benefits, the nature of qualitative research and the uncertainties inherent in social interaction and processes meant it was not possible for

me to know and therefore inform participants in advance about the consequences of participation in the study (Shaw, 2003; Dench et al, 2004; Hollway and Jefferson 2000; Corbin and Morse, 2003). In practice, the issue of consent was managed on an on-going basis. Participants were made aware of the various points in the study and of their right to withdraw consent at any stage. The issue of informed consent is discussed further in *3.7(4).*

3.7(2) 'Opening Pandora's Box': Attending to researcher distress

Being immersed in personal narratives about suffering can have an affect both on the teller and on the listener. As researcher, I had to consider the potential impact that listening to such information might have on me. As a qualified psychotherapist already working in a specialist eating disorder centre, not only have I been repeatedly exposed to many stories of suffering, I have undertaken specific training to tolerate and manage the affect that can result from listening to accounts of personal distress. In addition, I have developed skills to draw upon clinical supervision to address both professional and personal issues emerging from this type of work. It was agreed that I would have regular supervision with my PhD supervisors. Face-to-face supervision meetings continued on a monthly basis, as well as telephone consultation as required. A related issue was the management of my own physical safety during the process of conducting individual interviews. This is discussed in *3.8(1).*

3.7(3) Ethical approval

In order to access and recruit participants from across Scotland, ethical review and approval was required from an NHS Scotland Multi-Centre Research Ethics Committee. Application for ethical review was submitted on 28 November 2006 and approved following a committee meeting on 14 December 2006.

I was asked to confirm that I would not include participants who had undergone psychotherapy with me as their individual psychotherapist. The committee stated this would both influence and potentially impair the quality of data analysis due to the intimate knowledge I would possess about potential participants with whom I have worked. They also suggested that if I were listening as a researcher to accounts of my

own interventions as a psychotherapist, this might prejudice findings based on making interpretations of my own practice. The committee were satisfied that I would be able to include participants who had received psychotherapy within the treatment centre where I work, provided they had worked with another psychological therapist. Ethical approval was granted, based on my original proposal, allowing me to proceed with the study.

3.7(4) Voluntary participation and negotiating consent

Voluntary participation relates to the principle that participants are free to take part in or withdraw from the study at any time. In order to uphold participants' human rights, participation in research must be voluntary (Dench et al, 2004). All research methods have consequences (Mishler, 1986) and recognition of this is vital to enable voluntary participation to take place. Voluntary participation is not merely ensuring that the participants were aware that they could withdraw from the study at any time, although this was made explicit on a number of occasions throughout the research process. Participation in research can only be voluntary if the participant has access to relevant information about it and is able to offer informed consent. Therefore voluntary participation and informed consent are inextricably linked.

In seeking experiential accounts, it is impossible to anticipate and provide participants with an accurate description of the potential costs and benefits when consenting to participate. As far as possible, I sought to identify potential areas of discomfort or distress and discuss these with participants as part of the preparation stage. However, at the point of opening the semi-structured interview, I could not anticipate what participants would say in response to the questions asked and therefore predict how that questions and their response might impact on their wellbeing. Hollway and Jefferson (2000) discussed their concern about the issue:

> We were also aware of a (more) intractable issue concerning informed consent. We felt it was impossible to inform participants in advance in ways that would be meaningful, about the experience of our kind of interviews (page 86).

However, all of the participants within this study had undergone psychological therapy and therefore had acquired some experience of talking about sensitive personal issues to

a concerned other. This influenced my thinking that their consent was at least partially informed by previous experiences of sharing intimate information and their subjective account of important events and occurrences in their life, albeit that psychotherapy sessions and research interviews are not the same thing.

Furthermore, data acquired through an inter-subjective, experientially-based methodology can be understood not only as offering a description of the individual, but through the process of autobiographical narration, can inform the constitution of the self. Indeed, Lynch (1997) suggested the transformative effects of storytelling are precisely what can occur in psychotherapy as the client (re)forms their own self-narrative. A similar process can take place within autobiographical interviews and a number of researchers have highlighted the therapeutic potency of qualitative research interviews (Parr, 1998; Riessman, 1990). However, Day-Sclater, (1999) cautioned that the impact of a research interview can have both helpful and unhelpful effects on the self-concept of the participant and the researcher, and this must be borne in mind. Accordingly, it was important to inform potential participants about the ways in which their accounts may be used. This included sharing information on how the data would be stored (including the use of an audio recording device, electronic transfer by email, separate storage of information that could identify the participant such as personal addresses, postcodes, faxes, emails or telephone numbers), and storage of personal data on my home computer and work computer. It also included sharing information on how results would be reported and disseminated both to professional/academic audiences and service-user and/or community members. The former will include a copy of the research thesis being held at Edinburgh University Library, and a possible publication in a professional journal. Presentations at conferences are another possibility. The latter may include sharing outcomes at a Scottish Eating Disorders Interest Group (SEDIG) meeting or a summary being prepared for the b-EAT newsletter, SIGNPOST.

Finally, results from the study will be made available to research participants. My intention is to write to each of the participants with a summary of the process of the study as well as the substantive findings. This summary will also provide any known details of where and when the research may be published or presented. These issues were discussed when I gave participants the consent form. A copy of the consent form is

offered as Appendix 6. Informed consent was subsequently obtained in writing from all participants.

3.7(5) Anonymity and confidentiality

Confidentiality provides a safeguard against "unwanted exposure. All personal data ought to be secured or concealed and made public only behind a shield of anonymity" (Christians, 2003, page 218). Active steps were taken in the study to maintain participants' confidentiality using anonymising procedures. This included ensuring that information stored on computer was protected by a secure password and that names were changed (initially I used participant codes, and then changed to using a pseudonym when writing the thesis). Furthermore, demographic information, which might lead to the identification of the participant, is kept to a minimum. I also decided not to include a full description of the sample in any one place in the thesis, with the aim of offering a greater degree of anonymity to participants. On occasion, I have altered some of the finer details within a participant quote or when offering background information when I consider that it may allow the participant to be identified. This is particularly important where verbatim extracts may be used in published reports, which then inadvertently identify a participant (Elliott, 2005). It is a continuing tension to manage the participant's right to confidentiality while upholding the authenticity of the data. However, as with clinical practice as a psychotherapist, absolute confidentiality cannot be guaranteed and it was important to explain and discuss the boundaries of confidentiality prior to participation. For example, I anticipated that the process of gathering experiential accounts of recovery would inevitably require participants to share their views on possible predisposing, precipitating and perpetuating factors. Based on my clinical experience, I was aware of a possibility that disclosures may take place during the study, in particular, experiences of physical, emotional and/or sexual abuse. In the event of a disclosure that highlighted that a child or adult was in current need of support and protection, based on the Children's (Scotland) Act 1995 and the Adult Support and Protection Act (Scotland) 2007, it was agreed that I would discuss the need to act upon this information with the participant.

3.8 Data collection

3.8(1) The research space: Multiple locations

Participants were interviewed in a variety of locations between March 2007 and December 2008. The decision to interview in multiple locations was reached as this enabled me to respond to their needs, requirements and preferences. As Smith et al (2009) suggested:

> The site of the interview is important: a comfortable familiar setting (for the participant) is preferable, but also must be safe (for all parties) and reasonably quiet and free from interruptions (page 63).

I met three participants in a dedicated office at Edinburgh University. All interviews took place in the evening to fit flexibly with participants' other commitments. Two individual interviews took place in a city centre hotel as I had recruited two participants from the north of Scotland and met them while attending a National Eating Disorders conference in Aberdeen. I visited one participant at her place of work in Edinburgh as she had her own office. We organised the time of the interview late on a Friday afternoon to minimise interruptions. I also visited four participants in their own homes. Finally, I met two participants at my place of work at the inpatient treatment centre. One preferred to do this because she lived locally. She also wanted to meet away from her home, to have "some space from her children" to minimise distractions. Another participant had been a patient at the treatment centre and said she would prefer to meet me in a familiar context.

Each location presented particular logistical issues and some required further planning in terms of safeguarding the personal safety of both parties. For example, when meeting at the university, tasks included room booking and establishing clear meeting arrangements to allow me to bring the participant into the building in the evening when other classes were taking place. When meeting at the hotel, tasks included checking that the interview room was appropriate and making clear meeting arrangements when both participant and researcher were locating in an environment unfamiliar to both parties. When meeting at the participant's place of work, I was careful to ensure that I keep my details to a minimum in order to protect the participant's right to confidentiality. I told the

receptionist my name but not where I was from or why I was there. I simply said the participant was expecting me. For participants who visited my place of work at the inpatient treatment centre, I was aware of the impact of entering a hospital environment where other people were receiving active treatment for severe eating disorders. I discussed this in advance with both participants. The participant who preferred this location due to privacy and convenience said she did not anticipate that seeing current patients would create undue distress. I clarified this with her at the end of the interview and she said that the exposure to other sufferers reinforced her "gratitude for being recovered". For the participant who had previously been an inpatient at the treatment centre, she talked about the value in coming back to the hospital for a purpose other than to receive treatment. She said it felt helpful to be there in another capacity and to be able to go home at the end of the research interview. I considered that this may have been another motivating factor for the participant to engage in the study: to be able to relate to me as a researcher rather than a member of the treatment team and to be able to experience the treatment environment as a visitor rather than an inpatient.

For the four interviews conducted in participants' own homes, I was mindful of the possible effects of having the interview in a domestic environment and subsequently leaving the participant within that environment afterwards. I raised this issue as part of the preparation and all four expressed their views that the benefits (including comfort, safety and convenience) outweighed any potential distress. Of these four participants, I had some previous knowledge of three of them. One was the mother of a patient who had been admitted to my place of work, another was the personal friend of a colleague and one was known to one of my PhD supervisors. However, one participant was recruited through the newspaper advertisement. This visit reinforced the necessity for a clear safety plan. I agreed to leave contact details both with my PhD supervisors and in a sealed envelope at my home. It was agreed that if I did not return home within an agreed timescale and was not contactable, then the participant's details would be passed to the police to make enquiries.

3.8(2) The focus group

The preparation and planning of the focus group took several weeks to organise. This included sharing information about the purpose of focus group with potential

participants, identifying a date that would maximise participation and locating an appropriate venue and time. It was finally agreed to meet on a mid-week evening in a room within the university.

Group dialogue and discussion ran consistently for 1 hour and 20 minutes. Although participants were aware that they did not need to share personal information at this stage in the study, participants responded to the general questions in a very open and personal manner. However, I observed that much of the discussion was focused on sharing experiences of treatment, including humorous exchanges about difficult aspects of treatment, such as being 'told' to drink supplements drinks, or their attempts to avoid being weighed. I noticed how the group relied on me to offer some structure and direction to the discussion by asking questions or offering reflections at certain times. I was then able to observe how the group used these prompts to share information and respond to information emerging from the group process.

The audio recording of the focus group was transcribed and by listening to the ways participants responded to certain questions, the construction of questions or the point in the discussion they were asked, this helped to clarify the questions employed and the positioning of them within the semi-structured individual interview schedule.

I also concluded that individual interviews may be a more useful method to access the level of detailed and intimate subjective information required and that I would not deploy further focus groups to collect data.

3.8(3) Conducting individual interviews

The individual interviews had a unique quality and all generated a detailed experiential account on developing anorexia, recovery and the role of psychotherapy. The impact of context on the individual interview was significant. For example, interviews undertaken in people's own homes seemed to support the telling of a more intimate narrative. In addition, where participants had previous knowledge of me as a psychotherapist, they adopted a somewhat 'taken for granted' approach to my basic trustworthiness and my capacity to tolerate intimate and potentially distressing narrative material. The interviews that took place in the hotel took significantly longer (almost two hours each)

and in listening back to the interviews it seemed that it was more challenging to create a sense of comfort and intimacy in a setting that was unfamiliar to both parties.

Participants' described a wide variety of personal issues relating to developing anorexia, recovery and the role of psychotherapy. However, none of them became overtly distressed during the interview. I think they had considered some of the issues they intended to share with me during the preparation stage. Moreover, I did not have to manage more complex tasks, such as attending to breaches of confidentiality based on the health, safety or welfare of the participant or others.

Notwithstanding their uniqueness, as I progressed through the series of twelve interviews at different venues across Scotland and prior to systematic data analysis, I was aware of noticing particular issues in the evocative stories being told by participants. Listening to one participant's account, I found myself being reminded of issues that previous participants had discussed in their interviews. I did not allow my awareness of developing themes to change or alter the individual interview schedule, but made notes in my field work diary that I was then able to refer to when I moved into the data analysis phase of the study. At the most fundamental level, their accounts about developing anorexia, recovery and the role of psychotherapy were also stories about a variety of other important and subjectively meaningful experiences. Indeed, a striking feature of the individual interviews was the clear views and perceptions participants had about developing anorexia, recovery and the role of psychotherapy. Their accounts were intriguing to listen to. I was struck by the complexity of ideas being shared and by the meanings participants shared about their experience of developing anorexia and their subsequent recovery.

As I have frequently observed in my work as a psychotherapist within an inpatient setting, participants in this study narrated detailed and meaningful stories about their illness and recovery experiences. Anorexia did not 'arrive out of nowhere' nor 'depart unexpectedly'. Detailed information on these accounts and my interpretations of them can be found in the findings chapters, Four, Five and Six.

3.8(4) The research relationship

In the previous section, I explored some of the therapeutic potentials of qualitative research and the costs and benefits this poses to participants and researcher. If one accepts that qualitative research provides an opportunity for therapeutic work, and then in the same way that a positive therapeutic relationship is necessary in psychotherapy, the same is true for the research relationship. Indeed, the researcher has the responsibility to foster the relational conditions that will enable the participant to contribute maximally and to feel physically and emotionally safe in the process (Miller and Glassner, 1997; Thomas and Pollio, 2002; Hollway and Jefferson, 2000). Accordingly, many of the interpersonal skills essential to psychotherapy practice were employed as potent research skills. Communication skills such as reflective listening, clarifying and pacing were important as well as attending to non-verbal communication such as body language, the shift between verbal communication and silence, eye contact, and mirroring. However, Smith et al (2009) helpfully suggested that regardless of their usual professional context, the researcher must find a 'research persona' that allow interactional habits that support the research process, and do not interfere with the research goals and tasks. As a psychotherapist, this included my awareness of my wish to exercise my psychotherapeutic capacity, authority and clinical judgement. I acknowledged my awareness of how I might engage with the data as a psychotherapist. Indeed, this is part of the fore-structure I brought to the research relationship. However, it was important not to allow a 'drift' into psychotherapy and to remain mindful to the primary purpose of the dialogic engagement: to engage in research. Using the interview schedule as a structure, I engaged in active listening and negotiated an interpersonal boundary with participants, which was warm, respectful yet functional.

3.9 Approaching data analysis

3.9(1) Interpretative Phenomenological Analysis

Qualitative research takes as its starting point an awareness of the gap between the object of study (in this case, subjective experiences of illness, recovery and psychotherapy) and the representation of it (stories told in a group and/or individual interview, that are later analysed and interpreted by a researcher). The process of interpretation necessarily

seeks to fill the gap. However, in approaching data analysis, I acknowledge the gap between my wish to more fully understand anorexia and my attempts to do so. As researcher, this gap includes a profound awareness that data analysis is a process mediated by context and that any meanings generated are indexical and will change in response to the occasions they are used in (Moran, 2000; Schwandt, 1997).

Given the research aims to explore some of the human experiences involved in developing anorexia, recovery and the role of psychotherapy in recovery, I explored a range of data analysis methods with a phenomenological emphasis (Ashworth,2003; Dahlberg et al, 2008; Finlay, 2008; Giorgi, 1997; Halling, 2008; Todres, 2007; van Manen, 1990). However, given that I am strongly influenced by the Hermeneutic-Existential approach in phenomenology, in the use of narrative (verbal) accounts of lived experience and in the development of theoretical meanings derived from a fine detail analysis of individual experience, my method of data analysis was guided by Interpretive Phenomenological Analysis (Smith et al, 1997). Interpretive Phenomenological Analysis (IPA) places a particular emphasis on thinking about human experience, how we come to understand what happens to us and how we make sense of significant experiences. IPA supports the use of individual interviews to elicit narratives, thoughts and feelings about the target phenomena (see Reid et al, 2005, for a review) and is informed by phenomenology, hermeneutics and idiography.

There is no single method when adopting an interpretative phenomenological approach to data analysis (Smith et al, 2009). Nonetheless, Smith (1996) argued for an approach to psychological enquiry that was able to capture the experiential and qualitative aspects of people engaging in the world. Interpretative Phenomenological Analysis has yielded a variety of studies that explore a broad range of human experience. These include studies that explore psychological distress (for example, Macdonald, Sinason and Hollins, 2003; Newton et al, 2007; Carradice et al, 2002) and illness experiences (for example, Arroll and Senior, 2008; Wyer et al, 2001; Hunt and Smith, 2004; Daniel et al, 2005).

IPA is an integrative approach which "aims to allow the researcher to develop an analytic interpretation of participants' accounts which should be prompted by, and clearly grounded in, but which may go beyond, the participants' own sense-making and

conceptualisations" (Smith et al, 2009, page 186). This relates to Heidegger's exploration of way in which phenomena can *appear* in the interpretative process. He argued that appearance has a dual quality - relating to both visible meanings as well as concealed or hidden meanings. Hermeneutics engages both by examining hidden and visible meanings, which are always connected to deeper underlying meaning.

As with many other approaches in qualitative research, it is the analytic *focus* that is the common factor and not the precise methodological steps that are taken. In my communication with fellow researchers on the IPA internet discussion forum (ipanalysis@yahoogroups.com), I have found examples of a range of different methodological steps being taken. What these studies have in common is a set of processes informed by an underlying commitment to explore the participant's point of view, with a focus on personal meaning-making in particular contexts (Reid et al, 2005).

While there is not 'a method' of undertaking interpretive phenomenological data analysis, it seeks to facilitates the emergence of important themes that capture the most significant meanings and perceptions of each participant's account, in this case related to the development of anorexia, recovery and the role of psychotherapy. Although the idiographic nature of IPA is embedded in the particular aspects of experience and is cautious to arrive at generalisations, the methodological process encourages a journey from highlighting merely descriptive comment, for example, describing what a participant has said, to conceptual comments that aim to engage with the text at a more interrogative level which helps to identify emergent themes both within and potentially across participant' experiential accounts.

As well as exploring individual accounts, the purpose of hearing from a number of people who have suffered and recovered from anorexia is to explore the important themes that emerged across interviews, defined as superordinate themes. At a more abstract level, superordinate themes look for patterns between them, putting like with like to create a new means of clustering data together. Smith et al (2009) suggested:

> Themes are usually expressed as phrases which speak to the psychological essence of the piece and contain enough particularity to be grounded and enough abstraction to be conceptual (page 92).

My understanding of themes or superordinate themes are more aligned to Harre's (1979) understanding of data analysis, which locates interpretation within its context and therefore arrives at generalisations, such as themes and superordinate themes more cautiously. Furthermore, IPA is strongly influenced by the hermeneutic version of phenomenology. As Smith et al (2009) suggested "Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the Phenomenon would not be seen" (page 37).

3.9(2) Further components of data analysis

Although there is no single method for undertaking IPA, Smith (2007) cited in Smith et al (2009, page 79) suggested that IPA follows an iterative and inductive cycle which draws upon the following strategies:

1. A close, line by line analysis of the experiential claims, concerns and understandings of each participant;
2. The identification of the emergent patterns (i.e. themes) within experiential material, emphasising both convergence and divergence, commonality and nuance, usually first for single cases, and then subsequently across multiple cases;
3. The development of a 'dialogue' between the researcher, their coded data and their psychological knowledge, about what it might mean for participants to have these concerns, in this context, leading in turn to the development of a more interpretative account;
4. The development of a structure, frame or *gestalt* which illustrates the relationships between themes;
5. The organisation of all of this material in a format which allows for analysed data to be traced back through the process, from initial comments on the transcript, through initial clustering and thematic development, into the final structure of themes;
6. The use of supervision, collaboration, or audit to help test and develop the coherence and plausibility of the interpretation;

7. The development of a full narrative evidenced by a detailed commentary on the data extracts, which takes the reader through this interpretation, usually theme by theme, and is often supported by some form of visual guide; and
8. Reflection on one's own perceptions, conceptions and processes.

I will use these suggested strategies as a framework to explain the data analysis procedure and process that was undertaken, although points 5 and 6 will be integrated, as will points 4 and 7.

3.9(2) (a) Analysis of the experiential claims, concerns and understandings of each participant

The first stage of data analysis involved employing a process that would allow for a structured collation and analysis of the experiential understandings of developing anorexia, recovery and the role of psychotherapy in recovery. Although I recruited and met with participants over an eighteen month period, I used the time between interviews to transcribe interviews and used my fieldwork diary to record any reflections, questions, observations or theoretical hypotheses/assumptions that came up for me. I waited until all the interviews were completed before commencing in-depth data analysis. I did this because my analytic priority was to seek to adopt a phenomenological attitude or stance that encouraged me to look, listen, think, feel and reflect on my participants' storied accounts from their perspectives.

I started by reading and re-reading the transcripts and listening to the corresponding audio recording at the same time. This allowed me to identify richer or more detailed sections of each interview as well as contradictions within them. I began to note things within the transcript and made comments about the ways the participant talked about, understood or thought about developing anorexia, recovery and psychotherapy. This process was intensive and time-consuming and to some extent, I battled with the urge to move into the interpretative phase – to start to 'make my own sense' of what the participants were discussing and what issues were relevant across multiple transcripts. However, by actively aiming to retain a phenomenological focus, within each participant's individual account, I began to see a descriptive core of comments, which had a clear focus on the lived experience of anorexia, recovery and psychotherapy. These

comments also included more conceptual meanings which participants shared about each of the three areas of examination. I also noticed and commented on any linguistic issues, such as the use of metaphor, repetitive words or the tone, volume and pacing of speech. I was aware when I began identifying participants' conceptual understandings that this encouraged more of a dialogue with my own. For example, how does his/her conceptualisation of what is happening there fit with theories I might have about that issue?

Through this process of exploratory commenting, I highlighted particular sentences from the transcripts. Borrowing a term from narrative analysis, I called these principal sentences (Leiblich et al, 1998). According to Leiblich et al, principal sentences are "utterances expressing new and distinct ideas or memories about the content universe" (page 115). In this case, the content universe is comprised of participant's experiential descriptions and conceptual understandings about developing anorexia, recovery and the role of psychotherapy in a sufferer's recovery process. During this first stage of data analysis, principal sentences were highlighted from the text and filed in NVIVO, the qualitative research software package (QSR International, 2007). I then created a data analysis table for each transcript and placed the principal sentences for each interview transcript in the first column of the table.

Across the entire data set, I recorded 132 'principal sentences' related to developing anorexia, 112 related to recovery and 87 related to the role of psychotherapy in recovery. An example of this table is offered as Table 8.

Table 8: Principal sentences: Categorisation and analysis

Interview Participant Code: _____

SENTENCES	COMMENTS/ EMERGENT THEMES	THEORETICAL CATEGORY	SUPERORDINATE THEME

3.9(2) (b) The identification of emergent themes

During the second stage of data analysis, data was tabulated to move from an analysis of experiential understandings towards the identification of themes. This phase of data analysis required a focus on discrete pieces of transcript. I moved away from the 'story as a whole' to allow the analysis to take me further away from the actual participant to include more of my interpretative focus. At this point, I began to cautiously identify themes.

In the second column of Table 8, I made general comments about the meanings and perceptions I had through engagement with the data. I proposed themes and ordered these chronologically. The next step involved examining the ways in which these themes might link together. To achieve this aim, I allowed myself to begin examining participant's experiential claims bringing my psychological knowledge more deliberately to the process of data analysis.

3.9(2) (c) The 'dialogue' between the researcher, their coded data and their psychological knowledge.

While IPA research seeks ways to get close to the human experience being explored, this is a complex process, in which interpretation cannot be avoided. Moreover, particular phases of the data analysis process require a more active interpretative stance which enables analysis to move beyond a descriptive account.

An essential aspect of the data analysis process is to declare my fore-structures explicitly, draw upon them and make visible to the reader the analytical lens through which I was seeing the data. An important aspect of my fore-structures is my psychological knowledge and its integral relationship to the way I both experience and make sense of the research participants. Therefore, at this stage, I shifted yet further from the phenomenological to the interpretative side of the hermeneutic process to allow me to reflect upon the data as a psychotherapist and eating disorders clinician, drawing upon my psychological knowledge.

Having analysed the experiential claims of each participant and used these to identify emergent themes, this third stage of data analysis involved a deeper level of

interpretation by examining participant's accounts of developing anorexia, recovery and the role of psychotherapy drawing upon relevant theoretical models. As Smith et al, (2009) suggested: "IPA does systematically make more formal theoretical connections, but this is usually done after the close textual analysis and guided by the emerging analysis" (page 105). These models were selected on the basis that they were unquestionably the conceptual and theoretical understandings that I consciously had to 'suspend' when seeking to analyse data from within the terms of participants' personal accounts. They appeared in my own analytic lens in response to participant's subjective accounts and I hoped that by creating a dialogue between the participants' subjective accounts and my psychological knowledge, that I would be able to identify other useful understandings that would otherwise be missed.

Moreover, by the time I commenced data analysis I had already undertaken a significant amount of reading as part of the literature review and used this to help refine the focus for my research. As a result, I was inevitably drawn to particular theoretical models because of their potential to allow me to explore the un-examined areas in available knowledge that my literature review had elucidated. I see this as a further example of the mutually constitutive nature of the phenomenological and interpretative aspects of the research process.

Firstly, my review of available literature allowed me to establish my intention to examine subjective accounts of recovery alongside personal representations of developing anorexia. I hoped this would enable me to highlight potential meanings and understandings about the relationship between the two. Therefore, to begin examining accounts of developing anorexia, data was reflected upon in terms of Lask's model of predisposing, precipitating and perpetuating factors (Lask, 2000). This model is frequently adopted in the field of eating disorder treatment, reflects the multi-factorial aetiology of anorexia and is often used collaboratively with sufferers to assist in developing a psychological formulation for the development and maintenance of their eating disorder. This involved clustering participant's own accounts of developing anorexia into predisposing, precipitating and perpetuating factors. This is discussed in detail in Chapter Four.

Secondly, my literature review allowed me to clarify my focus on subjective accounts and understandings of the psychological changes that support the recovery process and in particular, the role of professional and non-professional help in supporting recovery and the relative contribution of each. As a result, to examine accounts of recovery, data was reflected upon using Lambert, Shapiro & Bergin's model of extratherapeutic and therapeutic factors in recovery (Lambert et al,1986). I decided to use this model as it is established on the premise that recovery may or may not involve treatment experiences and I wanted to explore this in a more systematic way. This involved clustering participants' accounts of recovery into those factors that occurred outside of their treatment experiences, as well as those which linked directly to the provision of psychotherapy. This is discussed in detail in Chapter Five.

Finally, my examination of the extant literature helped to establish my intention to examine the particular factors that make psychotherapy helpful, including both technical and non-technical aspects of psychotherapy, such as particular therapeutic interventions and the role of the therapeutic relationship. Given that participants had experienced a wide variety of psychotherapy approaches, across a range of treatment centres in Scotland, I was drawn to reflecting on the common factors that exist across such an expansive and divergent set of experiential claims about psychotherapy. Accordingly, to examine accounts of the role of psychotherapy, I initially reflected upon the data in terms of Grencavage and Norcross's list of positive factors in psychotherapy associated with a positive outcome, known as common factors (Grencavage and Norcross, 1990). This enabled me to reflect on participants' descriptions of therapy as articulations of support, learning and/or action factors.

Returning to Table 8, in the third column, each principal sentence with its corresponding theme(s) was categorised theoretically. It was important to use these theoretical constructs cautiously as my interpretations are yet another step removed from the original account. However, IPA can be helpfully understood as offering opportunities to engage in different levels of interpretation, which can include the use of more specific theoretical accounts. I understood this process as engaging with theory as a means of further exploring and understanding participants' perspectives. I did not see this as an opportunity to test it.

A summary of the theoretical models employed in the third round of data analysis is offered as Table 9.

Table 9: Summary of the content category and the researcher's interpretative frameworks

Content Category	Theoretical/Analysis Category
Developing Anorexia	Multifactorial Aetiology Model: Predisposing Factors, Precipitatory Factors and Perpetuating Factors (Lask, 2000)
Recovery	Therapeutic Factors and Extratherapeutic Factors (Lambert et al,1986)
Psychotherapy	Common Factors: • Support • Learning • Action (Grencavage and Norcross, 1990) Therapeutic Relationships: (Clarkson, 1990)

3.9(2) (d) The frame that illustrates the relationships between themes and detailed commentary on the data extracts

Using the data analysis table, I used the themes from each of the individual interviews, combined with my psychological knowledge to seek to arrive at superordinate theme(s). Superordinate themes have a greater degree of abstraction from the particular principal sentences and seek to create identifying patterns between themes and put like with like together. I examined the themes across the entire data set to aim to arrive at a collection of superordinate themes across all twelve interviews.

When exploring the main area of developing anorexia, the superordinate themes of Attachment, Trauma and Identity were identified and are discussed with detailed commentary on data extracts in Chapter Four. When exploring the main area of recovery, the superordinate themes of Definitions of Recovery and Factors that Support Recovery were identified and are discussed with detailed commentary on data extracts in chapter Five. When exploring the main area of the role of psychotherapy in recovery, the superordinate themes of Support, Learning and Action factors were identified.

However as data analysis progressed, important issues emerge that resulted in a move from a common factors approach (support, learning and action factors) onto participants' experiences of the provision of specific types of therapeutic relationships, namely the experience of the working alliance and developmentally needed/reparative relationship (see Clarkson, 1990). This decision was made on the basis of my observation that participants' accounts of the role of psychotherapy in their recovery process appeared to meaningfully connect to their accounts of developing anorexia. In other words, through the iterative process of working between the three sections of each interview on developing anorexia, recovery and the role of psychotherapy in recovery, across the entire data set and back again to each narrative account, I was intrigued to find that the therapeutic relationship that participants had with their therapist and the interventions their therapist utilised, appeared to me, to attend to or address some of the issues that they believed to be significant in the development of their eating disorder. As a result, an additional superordinate theme of the Developmentally Needed /Reparative Relationship was identified. A consolidated summary of all of the superordinate themes can be found in Table 11.

This posed a methodological dilemma at this point in data analysis. IPA is committed to exploring lived experiences from within the terms of participants' own accounts. In selecting superordinate themes about the role of psychotherapy in recovery which originate in psychological theory, I was concerned that I might be moving too far away from the phenomenological underpinnings of an IPA methodology.

However, my interpretations about the role of psychotherapy in the recovery process were embedded in each participant's experiential account. It was participants' descriptions of their psychotherapy experiences that led me to reflect upon their

descriptions both in terms of common factors across psychotherapy modalities and the provision of specific types of therapeutic relationship experiences.

As a qualitative researcher, it was important to maintain fidelity to the epistemological roots of the study whilst remaining flexible to allow the data to lead me to places that might help me to respond to my research questions. Therefore, I believe that the level interpretative abstraction that I reach in the final stages of data analysis remains within the boundary of a phenomenological methodology. I understand this as an example of Heidegger's suggestion that phenomena include both visible and hidden meanings and as researcher I wanted to remain open to 'seeing' both. This is discussed in detail in Chapter Six. The reader will see that the way that I present the findings in this chapter reflects a deeper level of interpretation and as a result offers a greater degree of abstraction.

3.9(2) (e) The organisation of material, tracing back through the process and the use of supervision

Each individual interview was transcribed and copies of transcripts given to both PhD supervisors, providing them with a detailed understanding of the experiential accounts offered by all twelve participants during individual interviews as well as the focus group discussion. Next, following the stages of analysis described in *3.9(2)(a)* to *3.9(2)(d),* copies of completed data analysis charts: Principal Sentences: Categorisation and Analysis for all twelve interviews were reviewed by my supervisors. This created openness and transparency about the ways in which analysed data linked back to their original source, allowing for further reflection and critical analysis of my engagement with the data.

3.9(2) (f) Researcher perceptions, conceptions and processes.

The centrality of hermeneutics in IPA, and particularly the idea of the double hermeneutic, make researcher perceptions, conceptions and processes highly significant in the interpretative process. Indeed, the findings from research of this type reflect the interpretations of both parties; first the participants' interpretation of their own experience and next the researcher's interpretation of those participants' understandings

of their experiences. As a result, it is critical for the credibility and trustworthiness of this study that a reflexive attitude and practice is adopted throughout the thesis to allow the reader access to both parts of the double hermeneutic. I therefore aim to make explicit my own perceptions, conceptions and processes at regular intervals and shall now summarise some of the central issues surrounding my interpretive stance.

Firstly, I shall restate my own phenomenological attitude and what Heidegger defines as fore-structures. Fore-structures refer to the prior experiences, assumptions and preconceptions of the reader or analyst. My fore-structures include and integrate a range of personal and professional influences. There is a significant temporal element involved in them, demonstrating how the role of prior experiences, assumptions and preconceptions alter and change over time.

In Chapter One, I share my fore-structures temporally, starting with academic exposure to the issue of body image concern as a social work student, moving to my training in integrative psychotherapy and most recently working within a multidisciplinary team within a specialist eating disorders inpatient setting. In sharing some of the main influences from my professional life, I hope to have conveyed the multi-dimensional nature of these influences on the entire study. Furthermore, my subjective experience of learning and *integrating* knowledge has been less concerned with strictly privileging a particular epistemological perspective. Instead, I value the discourses between perspectives, looking at common factors and differences and what each can offer to help further understandings of anorexia. Working in a multi-disciplinary team, this is applied on a daily basis as discussion and reflection on the issues associated with anorexia are generated from a range of perspectives, by people from different professional disciplines.

My epistemological position is primarily based on a Hermeneutic-Existential approach to phenomenological enquiry. This seeks to explore the nature of what is going on, rather than to encapsulate it in finite terms. Events are interpreted in relation to their context, and understandings are necessarily mediated through the inevitable subjectivity of the investigator and research participants. There is no truth just people; making sense of things based on situated perspectives.

The methodological challenge of working with fore-structures as part of the data analysis process is that they can encourage making assumptions or seeking to find what one is already looking for. This epistemological concern is of central importance in positivist science, which aims to minimise partiality and bias. However, from a Hermeneutic-Existential approach to phenomenological enquiry, fore-structures are acknowledged, tolerated and even valued as inevitable and potentially enriching aspects of the interpretive process.

Moreover, Gadamer (1990; 1960) proposed that fore-structures may not be known to the researcher at the point of embarking upon data analysis. They can be illuminated and even change as part of the interpretative process. In research practice, some of my own fore-structures were not fully revealed until I observed their influence on the data analysis process. In other words, the ways in which I was reading and responding to the data allowed me to understand the subjective lens through which I was examining the data.

Ways of managing the methodological danger of 'finding what I'm looking for' includes:

1. being aware of this danger and holding it mindfully during the phenomenological phase of data analysis;
2. adopting an open analytic attitude to allow a deductive process to evolve and enable the data to express or reveal meanings to me as the researcher;
3. ensuring that any inductive processes of data analysis are made explicit to the reader, particularly the use of theoretical models to make sense of data;
4. ensuring that data analysis is transparent to the reader so that judgements can be made about the findings; and
5. rigorously demonstrating evidence from transcripts to inform the reader of my process of data analysis.

The process of data analysis is also significantly influenced by the hermeneutic cycle. The hermeneutic cycle is concerned with the relationship between the part and the whole in this case, the relationship between the discrete sentences offered to illustrate particular points (the specific) and the full transcript (the whole story, or at least the whole story

based on the questions asked, in the specific context within which they were asked). As the researcher, I have engaged in an iterative process, moving backwards and forwards between the full transcript to single extracts and between individual interviews and the complete oeuvre. It is not possible to interpret single extracts without drawing upon the complete text and vice versa, each being informed by the other. Readers will not have had the opportunity to read full transcripts and will rely on these issues arising from the hermeneutic cycle being made explicit when reading selected extracts from interviews.

3.10 Critical reflections on methodological choices

At this point, I offer critical reflections on my methodological choices and highlight some of the strengths and limitations that a phenomenological methodology places upon data generation, data analysis and the subsequent findings that will follow in the next three chapters.

A phenomenological methodology is concerned with examining human issues and concerns as they are perceived and represented by individual people. The Hermeneutic-Existential approach is committed to personal meaning and sense-making in a particular context for people who share a specific experience. This approach relies on the participant's capacity to have awareness of, and the means to represent, their experiences to others and the researcher's capacity to seek to get close to that lived experience through the interpretative process. This involves a two-stage process through which the researcher tries to interpret the participant's sense-making activity. This 'double-hermeneutic' (Smith et al, 2009) seeks to identify and illustrate master or superordinate themes. Such themes represent meanings which are necessarily co-constructed. As a result, this methodology did not provide access to potential participants without this kind of self-awareness and communicative desire and required me to access and recruit potential participants who possess both.

In addition, IPA is predicated on balancing idiographic detail with commonalities across the research sample. As a result, this particular methodology respects the individual account and perceptions of each participant whilst attempting to balance this with an

account of what might be shared across the group of participants and indeed, a broader context.

This balancing connects to the issue of generalisability. While some methodologies (particularly those from a more positivist paradigm) seek to produce findings that are generalisable to a wider population, qualitative methods such as IPA conceptualise the issue of generalisability differently. There is an increased tendency to emphasis contextuality and the heterogeneity of more 'local knowledge' over the universal generalisation of the results. Given the emphasis on contextuality and the pursuit of more 'local knowledge', Smith et al, (2009) advocate a relatively homogenous sample that allows for an interest in and examination of both the individual case and the entire sample.

Essentially, IPA aims to produce findings which are concerned with theoretical transferability rather than empirical generalisability. Smith et al, (2009) suggested: "In this case, the reader makes links between the claims in the IPA study, their own personal and professional experience, and the claims in the extant literature" (page 51). By offering the reader a detailed, transparent and contextualised analysis of the accounts of participants, this affords the reader the opportunity to "evaluate its transferability to persons in context which are more, or less, similar" (page 51). Reid et al, (2005) considered that commonalties across accounts, situated with analytic commentary can provide powerful insights and understandings.

So far, I have mentioned a number of central methodological issues: IPA's reliance on human sense-making as a form of data; the role of researcher as an active meaning-maker and therefore IPA's reliance on human sense-making as a method of data analysis; the potential impermanence and variability of meanings arising from their sensitivity to context and the relationship between the research paradigm, the sample and the generalisability of findings. Each of these issues has a bearing on the data generated within this study, the data analysis process and the findings.

Firstly, I recruited a unique sample of people with particular things to say about a number of specific lived experiences. This sample includes people who wanted to talk to a researcher and did so within the context of this study. These are people who had

things they wanted to say about developing anorexia, recovery and their experience of psychotherapy. This sample contains people who have recovered from anorexia (according to the EDE) and possess direct experience of individual psychotherapy. As a result, the experiential accounts generated by this group of people will inevitably be influenced, to a greater of lesser extent, by the sense-making work they have undertaken during individual therapy. Therefore, this sample cannot be seen to represent a broad range of other people, such as those who might not want to talk to a researcher, those who don't have particular views and ideas about their lived experience of anorexia and recovery, those who have not received psychotherapy to assist in their recovery process, those who drop out of treatment altogether or indeed those people who recover without any professional interventions.

Nonetheless, this sample selection does offer insights into participants' personal experiences and meanings of developing anorexia, recovery and the role of psychotherapy within their recovery process. It is possible that their experiences and the meanings they have created about them may connect with a broader range of sufferers, but equally may not. In addition, the fact that their beliefs and understandings of developing anorexia and recovery may be influenced by their experience of psychotherapy also offers valuable information into some of the potential ways that psychotherapy might influence people's thoughts, feelings and actions in support of purposeful change. Once again, their accounts into the ways that psychotherapy influenced their thoughts, feelings and actions may connect with other sufferers' psychotherapy experiences, but equally may not.

Secondly, it must be acknowledged that participants' accounts are unavoidably filtered through my own fore-structures. As a psychotherapist working in the field of eating disorder treatment, my analysis of the data is by no means as neutral activity. Although I have aimed to maintain an open and curious stance throughout the data analysis process, it is inevitable that I bring my own beliefs, ideas, conceptions and understandings to the data analysis process. It is possible that a different researcher, drawing upon their own fore-structures would interpret the data differently and may or may not produce different findings. Accordingly, the findings from this study can be best understood to represent a co-construction of meanings in a particular context, at a specific time, for a dedicated purpose. They are inter-subjectively bound.

Nonetheless, through rigorous supervision, in which my supervisors saw both the original transcripts of all semi-structured interviews and all of my subsequent analysis as described in *3.9(2),* coupled with regular and repeated use of direct quotes from participants' accounts, I hope to demonstrate that my findings reflect a 'close enough' engagement with each participant's personal account. This does not afford the level of triangulation or member checking that a research team would, but it ensures that my interpretations and subsequent findings have been scrutinised. Considered in relation to the extant literature described in Chapter Two, I hope to afford the reader the opportunity to assess the credibility, transparency and coherence of my findings in spite of the inherent limitations of my methodological choices. These issues will be revisited when I discuss the limitations of the study in Chapter Seven.

3.11 Methodological summary

In this chapter, I have discussed the broad aims of this study and explored its philosophical roots and the theoretical assumptions I bring as researcher. I have highlighted the benefits of deploying a narrative-based phenomenological methodology to facilitate the exploration of complex human experiences, such as the development of illness, the process of recovery and the use of psychotherapy to support healing.

I have also provided a rationale for the use of IPA as a methodological guide in data analysis and explained the procedure for data analysis in detail. I introduced the reader to the twelve participants by providing some background information on the sample in Table 6. This introduction orientates the reader to the people involved in the study and contributes to setting the scene for chapters Four, Five and Six, in which I share the main findings of the research. Chapter Four is devoted to findings on Developing Anorexia. Chapter Five is devoted to findings on Recovery. Chapter Six to devoted to findings on the Role of Psychotherapy in recovery from anorexia.

Finally, in Chapter Seven, I bring together the main findings from this study and how these relate to existing literature. I discuss what this study adds to knowledge in the field of eating disorder research and explore the implications of the findings for

psychotherapy practice and eating disorder treatment in general. I also highlight the limitations of this study and point towards areas for future research.

4 DEVELOPING ANOREXIA

4.1 Introduction

When invited to discuss their experiences of developing anorexia all twelve participants identified either a singular or multiple proximal precipitant(s) that they perceived has a casual connection to the development of their eating disorder. For some these connections were clear and explicit, i.e., my anorexia was caused by *x*. For others, causal connections were more hidden or implicit and revealed by the progressive telling of the narrative and the way in which particular events or issues were organised and expressed temporally.

During data analysis, 132 principal statements relating to the development of anorexia were identified and recorded in NVIVO. The idiographic nature of an IPA methodology means that as well as observing and being curious about apparent similarities and commonalities within and between participants' interviews, I also observed and remained open to the uniqueness and differences within and across interviews. Each account has its own unique set of circumstances and individual twists and turns related to the development of anorexia. I sought to resolve this dialectical tension by acknowledging both positions and seeing the narratives as a collective set as well as a series of stand alone accounts. This allowed me to explore what insights and understandings could be found from each perspective.

Returning to the common themes across the entire body of data on developing anorexia, I was able to identify three overarching or superordinate themes. These superordinate themes recurred throughout the entire set of narratives and in some participant accounts more than one was present. They are defined as Attachment, Trauma and Identity. These superordinate themes represent a double hermeneutic – the participants' understandings of their experiences of developing anorexia and my interpretation of the participants' accounts. They include the phenomenological and interpretative aspects of the data analysis process and offer a dialogue between the data and my psychological knowledge as a psychotherapist.

4.2 Superordinate theme 1: Attachment

Eight participants discussed a range of familial factors that they believe were critical to the development of their eating disorder. These include examples of low levels of parental responsiveness and availability, ('Caring Less') for Janice, Pamela, Rosie and Caitlin, mental ill-health or personality difficulties with one of their parents, ('Less to Give') for Emily, Bethany and Caitlin, problems in the marital relationship, ('Just Like Your Father/Mother') for Emily, Ailsa and Pamela and parental/familial body image disturbance, ('I'm Not Ok and You're Not OK') for Bethany, Ailsa, Rosie, Janice and Nadia. As discussed in Chapter Two, there are differing views in the literature regarding the role of interpersonal factors in the aetiology of anorexia and diverse and oppositional arguments on the role of the family in contributing to the development of eating disorders. However, when participants were asked what they perceive was significant in the development of their eating disorder, all mentioned interpersonal factors, and eight specifically discussed issues within their family system.

Exploring the data set surrounding family relationships, I began reflecting on what might pull each of these themes together; in the way a magnet might attract certain particles. If family relationships are themes, I was aiming to identify whether there is a superordinate theme that could meaningfully link the issue of family relationships together.

After examining Janice's transcript, I woke in the middle of the night with the idea that these types of familial factors are connected by a unifying issue: difficulties with attachment. Before defining 'difficulties with attachment', it is worth commenting on this particular example of data interpretation. Schleiermacher (1998) suggested that interpretation is, in part, an art form, which includes a combination of skills including intuition. Having been significantly immersed in the data, this type of intuitive deduction was able to take place.

Returning to define 'difficulties with attachment', research over the last thirty years has postulated that a child's early attachment relationships are paramount to assist their development of physiological, neural and behavioural responses to the world (Bowlby, 1988; Siegel, 1999; Cozolino, 2006). Moreover, the interaction in early

attachment relationships and the emotional nature of these interactions, create an "implicit" knowledge base of how to live in the world, an internal working model (Stern, 1985; Bowlby, 1988; Fonagy et al, 1998, Gergely et al, 2002). This includes the use of two different forms of memory, named explicit and implicit memory:

> Explicit memory involves the retention and recall of material that is consciously experienced whereas implicit memories may be acquired without awareness of their acquisition (Grigsby et al, 2000, page 85).

Building upon Bowlby's work on attachment theory in the early 1970s, Ainsworth (1979) subdivided attachment into three main categories, creating the ABC model of attachment styles. Type A refers to a dismissive style that minimises the importance of relationships and negative affect associated with them (classified as ambivalent /avoidant), whereas Type C refers to preoccupations with close relationships and the negative effect associated with them (classified as anxious). Type B refers to a consistent and secure valuing of relationships (classified as secure). Although the aim of this study is not be examine attachment styles in sufferers of anorexia, through detailed analysis of the individual interviews, I observed Type C or anxious attachment styles with Janice, Bethany and Ailsa and Type A or ambivalent/avoidant attachment styles with Pamela and Caitlin.

A range of factors influenced the quality and style of the attachment relationship participants had with their primary carer(s). To highlight and discuss examples of these possible attachment styles, data will be presented under headings that capture the main ways that such interpersonal difficulties were experienced by participants and subsequently expressed during the research interview. By highlighting and discussing their experiential accounts of familial difficulties, I will link them to attachment theory and explore this superordinate theme further.

4.2(1) Caring Less

Bowlby (1973) identified two key features of the internal attachment model. The first relates to whether the attachment figure is the sort of person that responds to calls for support and protection and the second to whether the self is evaluated as the sort of person who elicits care from others. My interpretation of the accounts

given by Janice, Bethany, Pamela and Caitlin, is that they did not experience their parent(s) as sufficiently responsive and available to them. Accordingly, within their transcripts they describe how this influenced their capacity for and patterns of self-evaluation and in particular, how they came to evaluate themselves as being flawed in some way. In my opinion, Janice and Bethany appeared to develop an anxious attachment pattern, whereas Pamela and Caitlin appeared to develop a more ambivalent/avoidant pattern. The following examples help to illustrate the perception of a lack of responsiveness and availability on the part of a primary attachment figure.

Janice made a number of key points about parental responsiveness and availability. Firstly, she described a prolonged preoccupation with her father's evaluation of her. She told me that her anorexia was an attempt to transform herself from a girl to a boy; to become the boy her father wanted:

> "In fact, it was a way of almost turning into a boy. And that's certainly important because my father had wanted a boy".

Secondly, repeatedly throughout the transcript, Janice returned to issues of competitiveness, particularly with her sister who also developed anorexia. Janice described an unrelenting process of one-upmanship. I believe this form of constant striving might indicate an underlying anxiety: of not believing oneself to be sufficiently valued. Therefore attempts to excel may be a means of securing parental interest and pride, and ultimately care and protection. Janice described this vividly as "there wasn't room in the world for two of the same". For me, this evokes a sense of survival anxiety; that these children were attempting to create their place in the family through an evolutionary process of survival of the fittest (including cleverest, most attractive, most independent and resilient):

> "There wasn't room in the world for two of the same. So we needed to carve out how to share it. And she led the way there. She was the first one to get married, she was the first one to have a baby, she was (pause), in many ways (pause), it was like having an older sister even though she was younger than me. She overtook me at an early age".

While indicating the possibility of sibling-rivalry, this extract makes me reflect on the quality of her attachment relationship with her parents. I wonder why she would feel so threatened and insecure. Returning to Bowlby's features of an internal working

model, Janice may have internalised the beliefs that she is someone who is *not worthy* of care and protection and that her parents are insufficiently attentive and protective. When Janice lost weight, she perceived that this went unnoticed by her parents. She suggested this made her "sad":

> "The older I got the sadder I got, that nobody noticed. I think if they'd noticed Jackie (sister), and done something about it I probably wouldn't have had it because it would have been like modelling "well if you lose an unacceptable amount of weight, caring people make that uncomfortable."

When she referred to "caring people make that uncomfortable", my interpretation of this is her covert suggestion that her parents were not sufficiently caring, in fact they were negligent. By failing to notice or "make it uncomfortable", I hear an implied assumption is that they did *not care* for her sufficiently to notice problems with her weight. I think Janice is suggesting that her image of herself is defective and her image of her parents is neglectful. If this does express her internal working model, it could understandably be the basis for an anxious attachment style.

While Janice described her parents as being somewhat emotionally absent, the lack of parental responsiveness and availability for Bethany stems from her perception that she was the main caregiver to a vulnerable mother. She felt unable to seek emotional support from her mother:

> "I never really got over that barrier, even though we get on really, really well, I feel uncomfortable asking her for emotional support. I feel like I can't. I feel like it's not her role (pause) erm, it seems a bit daft really when it's your Mum".

When Bethany said "it's not her role" to offer emotional support, I believe this is another example of anxious attachment and specifically, what Salzman (1988) described as 'compulsive caregiving'. This is characterised by the child's insistence on taking care of the vulnerable parent and in doing so, denying their own need for care.

Unlike anxious attachment patterns, ambivalent/avoidant patterns are more likely to encourage the child to engage in 'false self-sufficiency' (Salzman, 1988). In this situation, the child may avoid caregivers and instead adopt an exaggerated,

independent stance. I believe this form of ambivalent/avoidant attachment behaviour was evident in the interviews with Pamela and Rosie.

Pamela lived alone from the age of 14 years because her mother was working away from home, her parents had separated and she did not wish to live with grandparents. Following Rosie's parent's divorce, she was permitted to live with her employer from the age of 15 years. For me, this raises concern about the quality of their attachment relationships with caregivers, when developmentally inappropriate and unsafe living arrangements were permitted and facilitated within these family systems.

Pamela described how the decision to live alone was reached:

> "Cause she was a single mother, and if you were a single mother you had to work. So it was either the choice of me living with her or my Grandpa (pause) because she didn't have a permanent contract in my hometown, so she was moved around every year to different locations. So she asked me, "Do you want to come with me? Or do you want to stay at home with your Grandpa?" And I said, "I can stay on my own!"

From a developmental perspective, it is highly unlikely that any 14 year old would possess the psychological, emotional or functional capacity to live independently. I believe this is evidenced when she stopped eating when she was at home alone. In the following extract, she describes taking an overdose and this can be viewed as a further signal of distress. Curiously, Pamela articulates the overdose as 'accidental' despite calling an ambulance, which later facilitated admission to hospital for treatment:

> "And I remember one night I was about to go to bed, when I lived alone, and then I just decided to live on coffee. If I was hungry I'd just have coffee. One day a friend of mine was in the flat and she left and I thought 'Oh I'll just have an aspirin and go to sleep'. So I went completely normal into the kitchen, drank lots of water, took an aspirin, drank it with coffee, nothing to eat at all that night, went over to the sofa and suddenly I started shaking really badly. Couldn't get up, called a Doctor or someone from the Hospital to come and pick me up".

Pamela said she thought she had only taken one aspirin when, in fact, she had taken 18. In the context of an insecure attachment, characterised by the child responding ambivalently and minimising overt displays of dependence on caregivers, it is

possible that Pamela may not have been able to express her separation-anxiety openly and instead displayed what Ainsworth (1979) and Main et al (1986) referred to as Type C behaviour. Type C behavioural strategies generally involve an exaggerated display of feelings to coerce the caregiver to respond and are typically employed when the child is uncertain about what the attachment figure will do. From my perspective, failing to eat and taking an overdose of medication are behavioural communications that she was unable to look after herself. However, for a range of reasons that will be discussed later, she was unable to communicate her distress directly with her mother or father. Salzman's (1997) study of ambivalent attachment in adolescent females with eating disorders described this as a "push-pull relationship" in ambivalently attached mother-child pairings. Maternal emotional inconsistency is a key variable in the adolescent's perception of personal distress. For me, emotional inconsistency is evidenced when Pamela talked about her mother's awareness that her daughter was struggling at home alone, but was "in denial" of it. In the following extract, Pamela describes her reaction to this "denial":

> "And she knew what was going on but was in denial that I'd got it, 'No I don't want to know about it, no'. So from being quite quiet and quite introverted (pause) suddenly I became really determined and very (pause) I'm not a bad person but there's quite a big difference between before and after".

I associate this extract with the emotions rage and despair. My interpretation of the overdose and dietary restriction is that these behaviours were employed to evoke a caring and protective reaction from her mother. When this did not happen and Pamela described becoming "really determined", I believe this to be an expression of her anger towards her mother, who appeared unresponsive to her distress signals.

In addition, Pamela described significant problems in her relationship with her father. Her parents had separated and she did not see him regularly. She described her father as being uncaring about her:

> "Well, my Father was never there, he never gave a fuck about me (pause) I was a bad kid, and in my Father's eyes I was a problem (pause) yet I was always trying to be good".

Returning to Bowlby's concept of the internal working model, if we accept the suggestion that a child develops a positive self-perception through the internalisation of lived experiences of being cared for by trusted others, it appears that despite Pamela's efforts "to be good", she eventually began to regard herself as undeserving of care. Irrespective of her efforts, her father did not provide consistent care-giving experiences:

> "I felt guilty all the way through my life. It could happen at any time, just that feeling of not being good enough".

In Compassion Focused Therapy, Gilbert (2010) adds to Winnicott's work about the importance of the human capacity for guilt. Winnicott suggested that guilt assists by making behaviours that are harmful to social relationships aversive thus helping retain solid reciprocal social relations. Gilbert discussed how guilt is focused on the experience *of the other* (as opposed to shame, for example, which is more focused on the experience of the self). If Pamela felt guilty throughout much of her life, the sense I make is that she lived in a state of being focused on the other and the other's negative evaluation of her. My interpretation is that Pamela had attuned to both parents and had acquired a negative self-concept through her internalisation of their ambivalent view of her. When she went on to discuss a wish to die, and the function of self-induced starvation as a means of eliminating "pain", I further interpret this statement as an attempt to rid herself of the belief that she was not worthy enough to have secured parental care. Indeed her early 'distress signals' did not prove to be effective:

> "And I remember over 7 weeks I lost a lot of weight and was just surviving on liquid. And when I was really, really frail, I was incredibly frail, I was happy to be dying. I wanted to go (pause) because that was the only time in my whole life where I did not feel any pain. And that is why I like to be like that".

I further interpret the function of self-induced starvation as a means of dissociation, a way of numbing her distress and providing emotional analgesia.

Pamela was not the only participant separated from her parents in adolescence. Rosie also found herself in an unsafe and developmentally inappropriate living situation, which I will discuss in *4.3*. In addition, Caitlin experienced a lack of

parental availability when she went to boarding school. She referred to this as a "strange environment" and the factor that initially triggered her dietary restriction:

> "It was a weekly boarding school and you went home at the weekend so I was kind of finding myself in a strange environment and I didn't take to it very well (pause) at all".

Eventually, the severity of Caitlin's dietary restraint resulted in her leaving school completely and returning home, to "recuperate":

> "So I was about 16 when things went AWOL. Just completely lost the plot. Stopped eating completely. Er, for a few weeks, a month maybe. And then when I was 17, I (pause) was asked to leave school, so I left school at 17 to kind of (pause) recuperate".

Interpreting this extract from an attachment perspective, "things going AWOL" may be a further example of a Type C attachment strategy aimed at securing proximity and care from her parents. Throughout her account, Caitlin discussed problems with direct communication with her parents. If she were distressed or unhappy at boarding school, her communication difficulties with her parents could impair her ability to express this issue directly. Instead, her difficulties adjusting to boarding school and her separation from her caregivers was expressed covertly, adopting dietary restriction as the signal of distressed. Indeed, she said that her dietary restraint was employed as a means of communication, "being heard" and "getting people to notice me". My reading of this is that she wanted her parents to 'hear her calls' and 'notice' her signals for care and protection:

> "I think it was (pause) maybe the feeling that I wasn't being heard, I was, I was using it as a way of getting people to notice me".

This statement makes me think about the way in which a child's attachment system will be activated in the face of threat or perceived danger and how this threat will be manifested in the child's safety-seeking behaviours. From such a position, anorexia can be understood as a means of activating the attachment system from caregivers.

In summary, whether evidenced by minimal parental expression of emotional warmth and attunement (Janice), minimal reinforcement of the parenting role (Bethany), or

physical separation from parents (Pamela, Rosie and Caitlin) these participants described perceptions relating to low levels of parental responsiveness and availability. Within their individual accounts, they also share their views about why their parents demonstrated suboptimal levels of responsiveness and availability. These include the influence and effects of other stressors, such as difficulties within the marital relationship, body image concerns in a parent or other family member, or parental mental ill-health or personality problems. I will discuss each of these stressors in turn, turning next to mental ill-health or personality problems with a parent.

4.2(2) Less to Give

For some participants, I interpret that their attachment relationship with their caregivers is affected by parental mental ill-health or personality difficulties. Emily referred to her mother's mental health difficulties:

> "My mother herself had a lot of problems, and when I look back now I can kind of see (pause) she certainly had quite a severe mental illness which I think impacted on me, and (pause) I mean (pause) I would put it down as (pause) um (pause) from reading about it, sort of emotional abuse (pause) I mean she was really kind of seriously very abusive towards me and I think I found that really hard, um, I mean there was (pause) um, I mean she definitely (pause) she definitely was (pause) um, she was under psychiatric care for a long time when I was growing up, um (pause) and very depressed. So that kind of whole (pause) the way she treated me was really difficult, just in ways that's kind of difficult to describe (pause) um, but I was kind of like, quite scared of her and quite (pause) um, pressurised into doing things like behaving in a certain way".

To comply with her mother's expectations, Emily articulated a process where her own needs were thwarted. She described it as suppression:

> "It's like I've been kind of suppressed".

My interpretation of "suppression" is that it conveys a form of parental over-control. Parker (1983) suggested that overprotection and control are the antithesis of promoting independence and autonomy in that they slow down and restrict a young person's essential socialisation. In Emily's account, this meant her mother had significant influence over many aspects of her day-to-day life, but in an intrusive and

critical manner, perceived as judgemental and restrictive. This idea is reinforced when Emily talked about the meaning of losing weight and becoming thin and specifically an association between being thin and being separate from her mother:

> "To be myself, maybe I thought I needed to be thinner, I don't know (pause) or to be different, which obviously didn't work. Um (pause) but when I was actually (pause) got away from the home environment, I knew I was different, I was able to sort of relax and just be".

Emily referred to a process of being 'moulded'. This word appears to be a powerful metaphor relating to the struggle to follow her development process of individuation and identity-formation as a young adult:

> "Cause I think I thought she was kind of moulding me, and (pause) but she was so dominant that it was difficult for me to actually be different".

My interpretation is that losing weight was a means of creating her own mould, of moulding herself. In doing so, Emily was challenging the potentially intrusive and infantilising strictness of her mother's low-care and high-control parental style and seeking to continue with her developmental task of growing up and establishing an autonomous identity. However, Emily's description of her complex developmental trajectory can be understood in relation to her ambivalent attachment relationship, significantly affected by her mother's mental health difficulties.

Bethany also reported vulnerability in her mother's mental health. She accounts for this, in part, as a consequence of her mother's own interpersonal history. Her grandmother exercised significant levels of control and influence over others, including Bethany's mother. She also had particularly rigid views regarding food, eating, weight and shape. This may have influenced her mother's internal working model and her mental health generally, and in turn, influenced the way she was able to parent Bethany:

> "Mostly my Grandma's own issues were laid out through me and my Mum which was all (pause) it's actually a wonder we've all come out as sane as we have (pause) erm (pause) my Mum was quite emotionally needy when I was growing up, and I remember that she was always very uncomfortable about her body and was always on some diet or another

> but often (pause) she was always obviously very upset about how she looked and I would always comfort her. And I remember always (pause) when I was little, comforting her whenever she got upset".

It would appear that Bethany adopted a care-giving role to her mother.

Returning to Caitlin, I interpret that the attachment relationship with her father was affected by, what she described as his "narcissistic personality traits". She told me her father reflected on her eating disorder in his own terms, through a somewhat egocentric process involving what his daughter's anorexia was like for him and how this might reflect on him as a father:

> "I think he's got elements of narcissistic personality disorder. So (pause) I was ill and that reflected badly on him. So I think he saw it like that (pause) he was very upset that he'd failed as a father and it was kind of his (pause) it was all very terrible for him!".

Narcissism is characterised by grandiosity, entitlement, inflated self-importance and limited empathy for others. In this extract, Caitlin appears to be suggesting that her father's high levels of egocentricity significantly impaired his capacity to reflect on his daughter's needs. Accordingly, she may have internalised that this key attachment figure is not the sort of person who can be relied on to think about and care for her. This may have contributed to the development of an ambivalent attachment style where her needs had to be suppressed and/or communicated covertly as has already been discussed.

In summary, the internalisation of an internal working model through repeated attachment patterns can also be influenced by the mental health and personality of significant attachment figures. This highlights the transgenerational process of attachment dynamics and the ways in which a caregivers' capacity to attach to their child will be influenced by their own early attachment experiences, their own internal working model. This is a helpful consideration when working therapeutically with individuals or families as it mitigates against taking a judgmental and blaming stance. It acknowledges that attachment capacity is directly connected to "good enough" interpersonal and intra-psychic experiences. This will be revisited in Chapter Six, which explores the role of psychotherapy and how it may respond to such issues.

4.2(3) Just Like Your Father/Mother

A further factor that I perceive to influence the attachment relationship between participants and their caregivers is difficulties in the marital relationship. This issue was relevant for Emily and Ailsa.

As discussed, Emily perceived her relationship with her mother had a causal link to the development of her anorexia. I will now discuss her perception that the quality of her attachment relationship with her mother was also adversely affected by problems within her parent's marital relationship:

> "I was under a lot of pressure as I was growing up to sort of be kind of successful at lots of things and, um there was a lot of pressure to sort of do well at school and um (pause) I think there was um (pause) maybe because my mother didn't have a good relationship with my father (pause) I think there was probably like (pause) kind of a lot of expectation on me".

From an attachment perspective, there are a number of complex issues at play. The first relates to the parental relationship and the second the parent-child relationship. Emily described a process where she was expected to achieve and be successful within a familial context where the marital pairing was perceived as defective and failing. If her parents were dissatisfied or disappointed in each other, it is entirely possible that their hostility towards each other also led to hostile or ambivalent feelings towards their child. Ward and Gowers (2003) suggested:

> The feelings towards the child, particularly from the mother, will generally be positive, but ambivalent feelings may predominate, particularly if the pregnancy was unwanted or if the relationship with the father is poor" (page 120).

Unlike Type C attachment strategies aimed at coercing the caregiver to respond via exaggerated behaviour, Type A attachment strategies involve inhibiting negative affect to prevent attachment figures' anger and are associated with actual threat or danger. Although Emily does not discuss being in actual physical danger, she described her mother as "emotionally abusive". Therefore, her compliance with her mother may have been the most functional means of ensuring her safety:

psychological and/or physical.

A similar process was raised by Ailsa. She discussed her parents' relationship difficulties and how she witnessed and was privy to events she felt were inappropriate. Her parent's marriage was perceived as "out of control". Studying and weight loss were employed as areas of life she could take some control over. I believe these are expressions of her compliance. Indeed, her attempt to be 'a perfect daughter' was aimed at preventing marital separation and ultimately to secure the family system and her on-going care and protection from her parents:

> "They were splitting up and there were things going on (pause) and eh (pause) I saw, not in a physically violent way (pause) I probably saw things I knew I shouldn't have (pause) cos they were young. You know, they were seventeen/eighteen when they had me, so you know, they were young (pause) and I think I saw quite a lot and heard quite a lot and became embroiled possibly, in areas I shouldn't have been. So you know it was, yeah (pause) 'that's not stable'; 'I want it to be'. My mother and father's relationship and marriage affected me deeply when I saw it going wrong".

Their marriage was defined as "not stable". My interpretation of this from an attachment perspective is that Ailsa perceived the instability of the spousal dyad as a threat to her care and protection. Her internal working model became unstable and accordingly, she had to find ways of trying to create stability in the family system. Therefore, when Ailsa reports that she was a perfectionist child, I view this as a behavioural manifestation of her anxiety-based internal working model and her attempt, by making herself the 'best she could be' to safeguard her attachment system:

> "And I must have been maybe, 15, 16, a perfectionist at school, head girl, usual, you know, trying to be the perfect this, the perfect that, all that malarkey".

Perfectionism is a well-documented feature of anorexia, (for example, see Fairburn, 2005). As stated, I consider Ailsa's perfectionism as a response to two issues. First, perceived 'conditional acceptance' by her parents, which I discuss further in *4.2(4)*. Second, a means of problem-solving complex issues within her family system. This includes her attempt to be accepted by her parents and a method of achieving mastery, in what she perceived to be a chaotic interpersonal context:

> "There were things I couldn't control (pause) my parent's marriage and whatever. I could control, one (pause) by studying and two (pause) how much went down my throat and how much I weighed. They were the two aspects of life I could control".

In addition, I wonder whether her ill-health became a focus for her parents and an issue they could aim to resolve together. The structure of the mother-father-child triad or triangulation has been explored in relation to attachment and eating disorders. For example, Ringer and Crittenden (2007) proposed that in families where a child has an eating disorder, the spousal dyad may be troubled and the child is then utilised as a means of stabilising the marriage. Ill-health on the part of the child, for example, an eating disorder, has a function in providing the spousal dyad with the necessity to put other destabilising marital factors to the side in order to work together towards the shared goal of supporting their child towards recovery and health.

In summary, difficulties in the marital relationship may have impacted participants' internal working models of attachment through three main mechanisms.

- Disturbance in the spousal dyad can be projected into a child born out of the relationship (Emily). The child may grow up with the perception that if the marriage is defective, then the child must also be flawed in some way.
- In a situation of prolonged conflict and high expressed emotion in the spousal dyad, a child may become increasingly sensitive to this dynamic and through developmentally appropriate egocentricity, assume that one has both the responsibility for and means to stabilise such conflict by being "a perfect child" (Ailsa).
- Development of illness in a family system seeks to minimise other form of disharmony and offers an opportunity to put any differences to one side to work towards the goal of returning the child to health (Ailsa).

4.2(4) I'm Not Ok, You're Not Ok

A further factor identified by participants as contributing to the development of their anorexia were body image concerns in a parent or other significant family members.

This issue was relevant for Bethany, Ailsa, Rosie and Nadia.

Bethany's mother had difficulties with eating when she was younger and her grandparents adopted particular dietary rules on their own eating, influenced by their own body image concerns. Bethany suggested the disordered eating behaviours of significant adults in her life influenced her own attitude towards eating, weight and shape. A possible mediating factor between the two involves her introjection of messages from family members about what was acceptable (strict control over weight and shape through dietary restriction), and what was unacceptable (little control over eating, increased weight and changes in shape).

With Ailsa, her father made "a few innocent comments" about her weight. This appears to have been a significant precipitant:

> "I was always quite a chubby kid, and looking back on it, I'm not blaming anyone but, there were issues in the family with, weight and things, looking back on it now. And I recall I was starting to get a bit of self-consciousness about it. You know, I was a good eater and I liked my food and everything with a few "innocent" comments made by my dad and things about my weight".

Ailsa makes repeated references to her desire to please her father and make him proud:

> "It sounds like I'm blaming my father, and I'm so not, but I did know, that my father who had weight issues when he was a boy. I felt like he didn't like me fat. I wanted to please him".

From an attachment perspective, it is crucially important to be and remain acceptable to the needed other, in order to secure sustained care and protection and this is how I understand her need to please her father.

In addition, Ailsa mentions that both parents had body image concerns. In trying to understand the possible meaning of her own weight and shape concerns, I question whether she was fearful that her parents may project their own self-critical judgments onto their daughter. In other words, they dislike in her, what they dislike about themselves:

> "Looking back, my mother was never comfortable with her weight either. She wasn't fat but she was a young mum, and eh (pause) and still now, she has issues with her weight. Erm, my dad had issues with his weight (pause) cos he'd lost a lot from being fat or chubbier (pause) no, he was fat when I was younger. So, I think possibly, those issues, because they were there (pause) that clicked into me (pause) of (pause) not only can I do really well at school and be really clever and really nice to everybody, I can also be thin".

Similarly Rosie mentioned her father's weight problem and described her first attempt to restrict her dietary intake:

> "My dad has always had a problem with his weight, always been overweight and, out of the blue, I don't know why it wasn't a conscious thing, I went to, into the kitchen and on the back of this big cupboard behind the cooker and on the back of the cupboard was one of these diet regimes that had a list of all the foods with calorific content and it was talking about an 800 calorie diet. And (pause) erm, I remember thinking (pause) I could try to do that and lose some weight".

My interpretation of her attempt to lose weight is that it was in part an attempt to change something about herself (her body) that her father disliked about himself (his body). This may have been an attempt to make herself more acceptable to him. Furthermore, in *4.3* which explores the superordinate theme of Trauma, I explain that Rosie was both physically and emotionally abused by her father. Therefore, securing care and protection from her father was vital given his overt acts of violence towards her. In such a context, weight loss may even have been a safety-seeking behaviour.

Finally, for Nadia, the significance of weight loss is also attributed to her family system. She described her brothers as being skinny and said she experienced herself as being 'different' from them. She also mentioned her mother's sensitivity to physical appearance and image and how she would comment on changes in her children's weight and shape. This appears to have been experienced as intrusive and critical:

> "I guess, I think I was unhappy and I would have done something, whether it be (pause) I don't know (pause) I guess my family (pause) I have three brothers who are all really skinny and I felt I wasn't, like them. I think weight was an issue around my house. My mum was quite, erm, appearance-conscience. Yeah, there was comments like 'Oh, you've put on weight' or something. There were comments about how much all

of us weighed, not just me".

It is understandable that parents are important communicators of prevailing socio-cultural ideals of thinness (Rodgers and Chabrol, 2009). There are some studies which support the hypothesis that mothers communicate their weight concerns to their daughters (Davison et al, 2000) and that mothers and teachers express concern about their own bodies and communicate messages to girls about losing weight (McCabe et al, 2006). A study by Vincent and McCabe also found that negative comments from parents about body shape is linked to body dissatisfaction (Vincent and McCabe, 2000) and that such comments lead to an over-evaluation of physical appearance which can then result in disordered eating (Wade and Lowe, 2002).

Connecting parental body image concerns to the process of interpersonal attachment and the development of an internal working model, I would argue that parental body image issues, including the priority placed upon weight and shape as an aspect of self-evaluation, will influence how the parent will view and evaluate his or her child's body. Depending on the level of priority given to weight and shape, for example, people who highly value a particular body image ideal, and regard their child to be falling short of the ideal, this may affect the way they feel about the child and ultimately the attachment bond. I am reminded of mothers I have worked with in the eating disorder treatment centre, some of whom expressed high levels of concern about her child gaining weight or becoming fat. In younger people, I have also observed the same body image concerns being transferred onto pets and a number of young people underfeeding their pets as a result.

4.2(5) Attachment summary

In this section, I have presented a range of difficulties that participants perceived contributed to their development of anorexia. Participants' accounts were clustered as low levels of parental responsiveness and availability, mental ill-health or personality factors in a parent, difficulties in the marital relationship and parental/familial body image disturbance. A discussion of the superordinate theme of Attachment and how it relates to current literature on developing anorexia will be undertaken at the end of this chapter. The next section is focused on the superordinate theme of Trauma.

4.3 Superordinate theme 2: Trauma

Participants discussed a range of adverse life events that they believe contributed to the development of anorexia. Examples include sexual abuse ('Inside, Shouting Out'), for Leah, Rosie, Nadia, and Anna, various personal losses ('Things that Changed Things') for Anna, Rosie, and Bethany, forms of emotional abuse ('Blamed') for Rosie, Emily, and Pamela, and physical abuse ('Nearly Blinded') for Rosie. Utilising the same inductive/deductive process of data analysis, I explored what might link these experiences together. I believe that participants were not only describing difficult life events, but also narrating the subjective experience of trauma. It is important to differentiate the two, as one does not necessarily follow the other. For example, many people experience a range of challenging and adverse life experiences but are not necessarily traumatised by them. For others, experiences are so profoundly stressful and overwhelming that they traumatise the person with potentially lasting consequences.

Traumatic events are typically so extraordinary that they would frighten and distress anyone. According to Schiraldi (2000) they are perceived as dangerous to self or others and overwhelm our capacity to respond adequately. Traumatic events can involve acts of nature or natural disaster, such as the 2008 Tsunami in Thailand or the random attack on baby twins by a fox in South London in 2010. They can also be caused by human action. For example, the case of the multiple murders of 12 civilians in Cumbria in June 2010 is an example of intentional human trauma, which was deliberate and assumed to be malicious. On the other hand, the example of a 16 year old schoolgirl killed on a coach crash would represent an unintentional human trauma that was accidental.

When exposed to such overwhelmingly events symptoms of Post Traumatic Stress disorder can result. The symptoms are understood as the disabling of normal coping responses by abnormally stressful events (Herman, 1992). Therefore adverse life events can be stressful but need not necessarily lead to a traumatic reaction and would only do so if the person's environmental stressors exceeded their own coping threshold. The consequences of symptoms of trauma can include the re-experiencing of the event and/or persistent avoidance of stimuli associated with it.

Having worked in general mental health settings as well as a specialist eating disorder treatment centre, my experience is that people seeking help for anorexia suffer from significant levels of trauma. Such was the demand for trauma based therapeutic input at my place of work, that in 2006, I undertook training in Eye Movement Desensitisation and Reprocessing (EMDR) therapy, an integrative therapeutic protocol designed for the psychological treatment of trauma (Shapiro, 1986).

The next section of this chapter will focus on the particular trauma of childhood and adolescent sexual abuse, and participants' perceptions of the relationship between this form of trauma and developing anorexia.

4.3(1) Sexual abuse: 'Inside, Shouting Out'.

A third of the participants discussed being sexually abused in childhood and/or adolescence and all of them connected it to the development of their eating disorder. This experience is relevant for Leah, Nadia, Rosie and Anna. Leah described it as the sole causal factor, Nadia as a major trigger factor, with Rosie and Anna citing it as a further trauma that served to maintain pre-existing anorexia.

These four participants offered accounts of the relationship between sexual trauma and anorexia and suggested a range of mediating variables. These include the perception of losing control of one's body in the event of sexual abuse (Losing the body), using the body to communicate 'unspoken' crimes (Body talk), and attempting to distance and dissociate from the emotional impact of sexual abuse ('Starve away' body shame).

4.3(1) (a) Losing the Body

Leah described how food and weight control were initiated in the context of being sexually abused by her father. Leah actually opened the individual interview by making a direct causal link between them:

> "And it was all to do with (pause) which I didn't know at the time because I'd absolutely blocked it out of my head (pause) my father had abused me. Me and my sister. And that's where it came from. And my thing was (pause) when I looked at food I thought of him. So I was saying no to it"

Unlike all other participants, Leah claims her eating disorder was triggered because she was sexually abused by the father. Her narration of the experience is very clear, "That's where it came from". Exploring her perception of the connection between the two, Leah explicitly talks about the centrality of control:

> "It was really a control thing for me".

The experience of exercising control over her body, her weight and shape, what she ingests (excessive quantities of laxatives, drugs and alcohol) and what she rejects (through various forms of extreme purging), can be considered in relation to what had been lost through her physicality. In a literal sense, she lost control of her body when her father exploited her for his own sexual gratification. Schwartz and Gay (1993) argued that by maintaining control over body weight, a survivor of childhood sexual abuse who develops anorexia is compensating for the absence of control when abuse was taking place. These behaviours serve to offer some sense of control over one's life (Slade, 1982). Both of these factors appear to be relevant to Leah's "control thing".

In addition, from an interpersonal and intrapersonal perspective, she also 'lost' her father, as a responsive and trustworthy caregiver. Kong and Berstein (2009) argued that depression mediates childhood sexual abuse and anorexia. In the next extract, Leah describes both her wish to die (hopelessness being a key symptom of depression) and her anorexia providing an alternative explanation for her wish to die:

> "I think I just wanted something to be wrong with me (pause) somebody (pause) like some mad illness and die. It'd be so easy, well easier than killing yourself, you know? I never had the guts to just sit there with a razor blade but I really just wanted to die. I didn't want to be there anymore, so that was my solution to it".

Leah felt unable to explain why she really wished "to die" (this would require her to betray her father's confidence), and therefore sought to find another way to express her

despair.

The idea that the body can be used to communicate what cannot be expressed in words is explored further in the next section describing 'Body Talk'.

4.3(1) (b) Body Talk

It took Leah many years to disclose the abuse (initially to her therapist and eventually to her mum). Like other participants, there is a quality of secrecy in her narrative when she told me about it. She described it like an unspeakable truth, communicated indirectly through a failing, weakened, de-feminised body. In the following extract, Leah articulates this nightmarish quality:

> "I can't even describe how it made me feel (pause) it's horrible. It's like, it's like somebody else taking you out of your body. Because you're inside, shouting out, but nobody can hear you".

This extract reminds me of Merleau-Ponty's notion of perception and judgment as an embodied experience. He suggested, "The body is no longer conceived as an object in the world, but as our means of communication with it" (1962, page 106). This raises an important issue about the message being communicated by people, when they engage in self- starvation following sexual abuse.

Similarly to Leah, Nadia also associated the development of her eating disorder with the experience of childhood sexual abuse. Interestingly, she said little about the abuse itself - for example, when it started, who the perpetrator was and how and when it ended. However, she commented in such a way to imply the significance of childhood sexual abuse in impairing her overall wellbeing and ultimately leading to the development of her eating disorder. The issue of secrecy and covert communication via the body is also illustrated in the following extract. In it, she describes a period of non-attendance at school. Nadia said it was not until people noticed she was losing weight, that they were alerted to the fact that there may have been a problem for her:

> "I didn't really tell anyone about the abuse but I was not going to school and getting into trouble for that. So there were other things happening around that time. And it was really only when I started to lose lots of weight that people became more (pause) interested I guess, for want of a better word".

My interpretation is that losing weight provided an opportunity for her to communicate distress. Nadia may not have been able to disclose the abuse overtly, but her dramatic weight loss helped to send a signal to others. In the context of sexual abuse, her eating disorder may be understood, in part, as a functional response to trauma aimed at eliciting care and protection, without making a disclosure.

I have observed this process repeatedly when patients are admitted to the inpatient setting where I work. They present with weight loss and apparent body image concerns associated with anorexia. However, as treatment progresses, the traumatic factors that triggered their eating difficulties becomes the central focus of treatment. I regularly discuss in my own clinical supervision if the eating disorder has been initiated, consciously or not as an attempt to alter an unbearable set of circumstances. For example, I worked with a 14 year old who eventually disclosed systematic rape by her father and a number of other men. The disclosure eventually resulted in alternative care arrangements being made for this young person. However the initial grounds for being removed from her family was for the treatment of anorexia. Her distress was communicated somatically before she could communicate her concerns verbally.

4.3(1) (c) 'Starving away' Body Shame

Nadia referred to concrete dissociative phenomena, which can also be a symptom of post-traumatic stress. In particular, she described dissociation from her own body:

> "I guess I always felt like I was too big. Erm (pause) just taking up too much space. I never felt very comfortable in my body. Erm (pause) I sort of saw it as something separate from me. (Laughs) You know I could be over here and change it (pause) and that wouldn't really affect me".

Her capacity to dissociate can be understood as a process of self-protection. By shifting her spatial and perceptual awareness during episodes of overwhelming

physical and/or emotional suffering, she was able to create distance from the abusive experience. She was able to experience herself as an *observer* of what was happening to her body, rather than the *subject* of this kind of suffering. However, despite being able to dissociate from her body, Nadia was not entirely protected from the traumatic episodes and began to experience high levels of dissatisfaction with her body:

> "I guess there was (pause) part, I was erm, sexually abused when I was I kid and I guess I found, it might sound simplistic and stuff but I guess I was very negative about my body from (pause) well, I can't remember not being. So it probably wasn't a surprise that I chose to do something (pause) to my body, yeah".

When she said she chose to "do something" to her body, my understanding of this is that by starving her body, changing the way it looked and felt, minimising and eliminating signs of her femininity by returning to a prepubescent state, she was attempting to alter the profound shame she felt towards that part of her 'self', her 'body self', that was at the centre of this trauma.

I believe that shame is also a significant issue in Rosie's description of being sexually abused by her employer. Given low levels of parental care and protection, she had become reliant upon the perpetrator for emotional support. She narrated an untenable situation of 'bargaining' with her body (i.e., "not fighting him") in order to safeguard continued emotional support, (to "talk about my feelings"):

> "And it became a kind of blackmail situation where he would kind of, if I wanted to talk to him about my feelings, then I had to allow him to do, to do something, without fighting physically. If I fought physically, he'd do it anyway and I just wouldn't get to talk to him, so I didn't".

This type of bargaining process may have resulted in shame that was subsequently transferred onto her body. When she then described rape in egosyntonic terms, as an effective form of 'self harm', I believe this illustrates the level of shame she had come to experience and subsequently transfer onto her body:

> "And, also it was a good self-harm (pause) it hurt (pause) someone else was hurting me so I cut less. Erm, and also (pause) just having him take my clothes off and be naked in front of him, made me so ashamed of my body".

Anna was also sexually assaulted, at the age of 16, by someone who lived in the local neighbourhood. She was unable to discuss this issue with anyone. Anna's shame appeared to stem from her belief that her level of intoxication contributed to the sexual assault taking place:

> "I was also sexually assaulted when I was 16, and I never told anybody about that either (pause) I never told a soul because I felt like it was my fault because I'd gotten myself so drunk again".

My interpretation of this extract is that Anna may have internalised a particular misogynistic attitude that certain behaviours on the part of women raise their complicity with such an occurrence - for example, the view that a woman is 'asking for it' evidenced by wearing certain types of clothes or being under the influence of alcohol.

Themes relating to depression and lowered self-esteem run throughout all of these extracts. These young women did not describe these abusive experiences as crimes committed against them. Instead, they seem to have interpreted them as indications of flaws or deficits in their basic sense of worth and competence, the cornerstones of self-esteem (Paterson et al, 1997). As Leah stated:

> "Don't know about anybody else, but when you're in the grips of that you feel like a (pause) a piece of shit Michelle. You feel as if you're nothing and you don't mean anything, and you're not (pause). You have no respect for yourself".

4.3(2) Loss: 'The Things that Changed Things'

Another important factor participants narrate as an important proximal precipitant in the development of their eating disorder, is various experiences of loss. Two participants experienced a significant loss prior to the onset of their anorexia. Rosie's parents separated prior to the onset of her anorexia and this led to significant changes to her role in the family, while Anna described the central importance of her decision to terminate her pregnancy as a key trigger for her eating disorder.

4.3(2) (a) The loss of childhood

Rosie opened her individual interview by explaining that from the age of 13 years she was responsible for caring and providing meals for herself and her sister. This increase in responsibility occurred in response to her parent's separation and changes in family routine and structure that followed:

> "Well, I was 13 and my, erm, at the time I was living with my dad and my younger sister and my mum had moved out, oh a year or year and a half ago. Erm and previous to that she'd kind of been there to cook meals for us. She and my dad had a fight and she stopped coming across and from that point on (pause) I started (pause) despite being only 13 (pause) started cooking for ourselves".

My understanding of this extract is that Rosie is describing a range of losses: the loss of her parents as a couple; the loss of family life as it had been and the loss of her role as a 'child' as she shifted to care for a younger sibling. Crisp's concept of a 'maturational crisis' may be relevant here, and in particular, anxieties surrounding the new and increasing range on demands placed upon her. I question whether her maturation process was hastened by the circumstances surrounding her parents' separation and the subsequent realignment of the family system. The quality of her description of her parents' separation was that it occurred suddenly and quickly. I think she was subsequently overwhelmed by the level of change and increased responsibility she faced. Confronted by the loss of her childhood, it is possible that she sought comfort in a psychobiosocial regression through self-induced starvation, an attempt to return to childhood and avoid the pain associated with its end.

4.3(2) (b) The loss of a child

At the age of 17 years, Anna discovered she and her long-term partner were expecting a baby. Although shocked, as the pregnancy was unplanned, they initially decided to have their baby. However, when both families became aware of the situation, Anna described being placed under considerable pressure to have a termination:

> "Cause I remember (pause) that was a hard time because (pause) obviously I told L (partner), and me and L spoke about it and we were like 'ok, ok we can do this.' I mean, I'm glad we did it in hindsight, I really am. Everything happens for a reason. But L told his mum and then all of a

> sudden he was like 'no, no, you should have a termination.' And I just felt devastated. He was like 'nah I can't do this, I can't do this' and his mum phoned me and she kept trying to speak to my mum and she kept saying to me 'right you need to get out of this, you can get out of this, don't be so stupid'".

Anna subsequently had a termination and I believe her narrative depicted this as a traumatic episode in her life. For example, she discussed the wish to lose weight immediately after the termination. She was specifically focussed on flattening her abdominal region wishing to remove any physical signs of pregnancy.

In addition, Anna was struck by the fact that following the termination, it was never discussed in the family again. She described her sense of disbelief that she met criteria for a diagnosis of anorexia. Anna was clear about her intention to reduce the size of her stomach after the termination:

> "I never ever thought I was anorexic. Same with L. Cause he was there and my sister was there, and they couldn't believe I was Anorexic. Cause I just (pause) I knew the word 'anorexic' but it just (pause) I just assumed that somebody who was anorexic just didn't (pause) well for me, it was somebody who was a nutter (laughs). Do you know what I mean? But I was just so used to wanting to get my belly down, that I didn't wanna eat, I was just 'No, I'm not hungry', it was part of me".

Anna's anorexia became the most extreme of all the participants, including lengthy inpatient admissions, detention under mental health legislation and near fatal consequences. She described these experiences in a somewhat disconnected way, as though dissociated from the obvious risks she was placing on her health, and ultimately her survival:

> "I was totally like 'nah, nah I'm fine, I'm fine, I'm fine, I'm fine' so no, even when they cried, even when I was sectioned, I couldn't believe it. I couldn't believe I was anorexic. Even at TP [name of eating disorder hospital] I didn't believe I was anorexic. But I really was, but I didn't care! I weighed 3 and a half stone, my family were all brought out and told I wouldn't live within the next 24 hours, and my family had been brought to say goodbye. Cause at that point my heart was starting to fail, and still I kept saying 'I'm fine, I'm fine, get me out of here'".

It strikes me that Anna's minimising of her anorexia is not dissimilar to her perception of her family's minimising of the termination. I question whether this may have been a recreation or re-enactment of a profoundly invalidating experience, in which Anna's complete denial of her self-induced starvation enabled her family to experience what she had when they encouraged her termination and then closed any opportunity for this to be discussed.

4.3(3) Emotional abuse: 'Blamed'

Emily, Pamela and Rosie all discussed experiences that I interpret to be examples of emotional abuse. For Emily, this included her description of her mother's emotionally cold and overly-controlling stance and the significant impact this had on her well-being. For Pamela, this involved her description of being allowed to live alone from the age of 14 years coupled with her impression (formed by her parents' behaviour) that she was not a priority to them.

For Rosie, as well as being sexually abused by an employer and physically abused by her father, she also described an emotionally abusive relationship with her mother. Towards the end of the interview, Rosie described her mother's reaction when she disclosed being sexually abused by her former boss. In the following extract, Rosie describes an invalidating response from her mother, suggesting she had known what had taken place and in some way had viewed this as a problem of her daughter's own making:

> "I told mum about Tommy, when I was 20 after he'd moved down south with his wife and I told her one summer after I'd been in the Royal for a month, and I was quite upset about it and came home and told her. I told her about him and she was like, 'oh well, you know, I knew about it'. And I was like, 'well why didn't you do something' and it all became this massive issue. Erm, and she basically blamed me for it".

Both the attitude and behaviour of Rosie's parents may be understood within the context of an impaired attachment relationship to their daughter. Deficits in the basic bond between parent and child, lack of care-giving, incidents of physical abuse, examples of neglect or failures to protect, poor empathy and low levels of warmth are the main themes within her narrative.

In the following extract, both physical and emotional abuse, are discussed and the effect these experiences had on Rosie's self-perception:

> "The physical abuse stopped when I was 11. Erm, he nearly blinded me one day. He punched me and I made a big deal of it (pause) I think it gave him the scare of his life and he thought that was it really (pause) Erm, and he never did it again. But the verbal stuff continued, he would tell me, how crap I was. I mean mum was the same, she'd say I didn't care about anyone but myself, I mean normal stuff, but beyond that, like saying, she wouldn't care if I dropped dead, and all this kind of stuff. And, dad was like, 'you're just a shit and worthless and erm, a little bitch (pause) everything, really (pause) you fucking this and that'".

Unfortunately, it would appear that Rosie internalised these messages and began to experience high levels of self-loathing. This would support the hypothesis by Leonard et al (2003), which proposed that early abuse may increase the risk of later abuse; in this case Rosie's physical and emotional abuse by her father increased her vulnerability to being sexually abused by her employer. Leonard accounted for this because the person who has been emotionally abused feels deserving of abuse and therefore more accepting of abusive relationships. This in turn may lead to a propensity towards risk-seeking behaviours. Rosie described a range of these including binging and vomiting, food and fluid restriction, cutting, and alcohol overuse. These findings would also be supported by Wonderlich et al (2001) who suggested:

> It is conceivable that the presence of multiple traumas sensitize an individual's psychobiological readiness for affective responding in a way that increases the likelihood of engaging ultimately in eating disorder behaviours. Often children are exposed to more than one form of abuse at any one time. For example, it is difficult to conceive how a child could be sexually or physically abused without also being emotionally abused at the same time" (page 410).

This was the case for Rosie, who was also physically abused by her father.

4.3(4) Physical abuse: 'Nearly Blinded'

Rosie talked about a range of incidents within the family, pointing to the experience of both physical and emotional abuse. The following extract is a key statement within the transcript:

> "Basically, my dad had been abusive when we were younger, like physically and verbally. And, I didn't have a problem with that particularly cos I didn't realise that something was wrong. But when I got to 14-15, I suddenly realised that, actually, this was not ok. And it became a real issue for me. So that was the reason for it starting".

Rosie described her growing awareness of the discrepancy between the way her father treated her and the way non-abusive fathers treat their children. Growing older enabled her to gain insight into the toxicity of her family environment. Sadly, I believe this realisation and insight was traumatic. I understand this as a response to her awareness that her parent's general approach and behaviour was intentionally harmful, which creates a different set of meanings. Her family experiences stopped being "this is what families are like" and led to more painful questions such as "why is this the way my family is?" or "what is it about me that makes family life this way?" This appears to have led to a range of negative perceptions about herself, other people and the world.

4.3(5) Trauma summary

There continues to be a lack of consensus about the precise causal relationship between histories of trauma and developing anorexia. This is an area of increasing interest and investigation, including assessing the relationship between anorexia and discrete types of trauma such as forms of abuse, neglect and other adverse life experiences.

Whatever the precise casual connections, I am struck by participants' descriptions of traumatic experiences and the direct associations they make between those experiences and the development of anorexia. Their experiential accounts about developing anorexia therefore became stories about an array of other important and subjectively meaningful life events. Of vital importance is the way in which the

authoring process positions the participant as active agents in his or her own life. From such a perspective, anorexia is not simply an illness experience, but involves a process of decision-making employed for particular purposes.

McAdam (1993) commented on the process of remembering our past experiences and suggested our remembrance of things is highly selective and it involves substantial reconstruction. Therefore, storytelling becomes more than a descriptive account, a recollection of events, but a process by which a self, with an evolving identity, is being created and recreated in the telling of it. Autobiographical narrating is a process that affords the teller opportunities for identity formation.

In addition to this, for two participants, I interpret their personal story about developing anorexia as one which relates directly to the issue of identity.

4.4 Superordinate theme 3: Identity

The accounts of the two youngest participants did not appear to fit within the superordinate themes of Attachment or Trauma and seemed to reflect an additional higher-order (Smith, 1997) theme. Consistent with an IPA approach of data analysis, it was important to be aware of 'exceptions' within the data and respect the idiographic aspect of each individual account. This resulted in the selection of the third superordinate theme of Identity.

Craig aged 19, and Kate aged 20, provided accounts of developing anorexia in their teens, at 17 and 14 years respectively. They both narrated relatively recent experiences both of developing and recovery from anorexia. Both discussed the onset of their eating disorders within the developmental context of adolescence and growing up. Important issues included increasing and heightened concern about their evaluation by peers ('Am I Ok as I am?'), negotiating the separation process from parents ('Am I ready to go it alone?'), and the deployment of weight loss and dietary restriction as expressions of personhood, and in particular expressions of self-mastery ('Look what I can do').

Erikson created a psychosocial theory of development (Erikson, 1963). He argued the ego identity is fluid and changes based on new experiences and daily interactions with others across the full lifespan. He suggested that each psychosocial developmental stage offers unique dilemmas. Such dilemmas need to be worked through leading to the successful resolution of the stage and progress towards the next psychosocial stage and another set of developmental tasks and opportunities. These are categorised into eight distinct phases from infancy to late adulthood.

During adolescence (the fifth psychosocial stage), the transition from childhood to adulthood is a primary developmental task. The young person seeks to become more independent and begins looking to the future, towards career, relationships, and interests outside the family unit. The new and expansive nature of this developmental task requires the testing-out of various ways of being, in order to help clarify a consistent identity over time. To establish a consistent identity, the young person seeks to explore who they are as an individual, their values, interests and preferences and with whom they wish to associate and create a sense of 'belonging' to. This may involve clashes with the values of parents and/or peers, although peer relationships become crucially important as the adolescent prepares to separate from the family. Erikson argued that failure to develop a sense of identity can lead to *role confusion.* Without a clear sense of who the young person perceives themselves to be, issues with aimlessness and drift can manifest. This developmental conceptualisation continues to be highly influential in informing understandings of child development and therapeutic work with children and adolescents. For example, Steinberg (1998) suggested one of the most critical tasks in adolescence is the process of achieving a stable, positive adult identity whilst giving up parental dependence.

Despite compelling arguments that disturbances in identity development are important in the aetiology of anorexia, there is no clear definition of what is meant by identity within the literature (Stein and Corte, 2007). These authors utilised Westen and Heim's definition:

> Identity is conceptualised as a global construct that refers both to the process of building a self-definition as well as to products of this process including knowledge about the self related to personal attributes and social roles (Westen and Heim 2003, cited by Stein and Corte, 2007, page

59).

They added that this includes the development of a self-concept, which will include self-certainty, sameness and continuity over time (Campbell et al, 1996). This definition has been deployed during the interpretative phase of data analysis with Craig and Kate's individual accounts.

4.4(1) Evaluation by peers: 'Am I ok as I am?'

Kate described a range of factors that she perceives are significant in the development and maintenance of her eating disorder including temperamental vulnerabilities; puberty; anorexia as supportive to academic success and bullying by peers about her weight and shape. Her narrative depicts an anxious young person entering into adolescence and encountering a range of physical, emotional and social challenges. Erikson's developmental model of the psychosocial stages and, in particular the adolescent stage of identity v role confusion offers a useful framework to reflect on Kate's sense-making about developing anorexia.

Kate presented a range of factors as important in the development of her eating difficulties, without placing particular significance on any one factor. To look at individual extracts of her interview may misleadingly imply that one factor was more important than any other. However, my subjective experience of being with Kate and listening to the interview as a whole, is that she offered broad and layered descriptions of the development of anorexia, whilst simultaneously discussing the complexities of adolescence and the myriad of development tasks to be worked through during this developmental stage. The superordinate theme of Identity formation provides an overarching meaning to her narrative. For example, Kate said she associates the development of her eating disorder, in part, with the experience of being bullied within her peer group about weight and shape:

> "I think like when I was thirteen and I did want to lose weight (pause) like I'll always remember somebody at school always used to make particular comments about my weight. And I know that I don't (pause) at the time I used to say it didn't bother me (pause) but I know it clearly must have bothered me. Looking back now it must have affected me a lot more than what I admitted at the time".

The combination of her temperamental vulnerability (she discussed being prone to high levels of anxiety as a child) and her negative experience of having been bullied by peers at school resulted in puberty being a problematic and challenging period:

> "I think when I hit puberty, because (pause) of just like (pause) other pressures and just changing and stuff physically (pause) suddenly. Now when I look back, I became so much more anxious about everything, and because I began to care so much more about what people thought about me and stuff".

My understanding of this extract is informed by Crisp's concept of anorexia as a "psychobiological regression" (Crisp, 1974, page 530), a "flight back into psychobiological childhood" (Crisp, 1970, page 454). The adolescent is protected from the "maturational crisis" (Crisp, 1979, page 63) of puberty, which is experienced as overwhelming. My interpretation of Kate's description of puberty is that she conveys the experience of being overwhelmed. The development of secondary sexual characteristics is profoundly significant biologically and socially: biologically as it is indicative of reproductive capability and socially as it arouses sexual interest from others. The relationship this has with eating is the biological and symbolic fusion with sexuality, procreation, and continued maturation, as Kate described it "changing and stuff physically". Crisp argued that this results in the need to organise consistent and reliable structures and controls *internally*. Altering weight and shape may result in external changes to the body, but equally represents an attempt to establish a mechanism to exercise and experience controls internally.

Similarly, Craig identified that his eating disorder developed in the context of comments made by peers about his weight and shape. He explained how these critical comments were internalised, "taken in", and how this led to worries and concerns about being "fat":

"It gradually just got like, you know (pause) em (pause) you felt you were fat and stuff like that and you know (pause) you would get comments off folk saying 'Oh look at your wee podge' and stuff like that and then gradually you would like (pause) you know (Pause) you would start to take those comments in and start to think 'Oh I

am quite fat', you know and then you start to worry about your weight".

Given Craig's developmental stage, the importance of evaluation by peers would have been crucial and his weight loss appears to be a means of guarding against criticism from others:

> "When you go through school and stuff like that you're always quite worried about, you know, folk saying anything to you and you don't, don't (pause) you're at that age you know, where you don't want anybody to say anything to you or anything like that and then (pause) I suppose you are at quite (pause) a (pause) eh (pause) tender age".

Craig also referred to developing facial acne, which was another perceived deficit with his appearance. He mentioned "being given abuse" which I interpret to mean a form of verbal bullying. He also described feeling unable to defend himself, which may have added to his overall perception of helplessness:

> "I had spots as well which you know (pause) you do, you get hassled for that as well eh. But I don't know (pause) the now I can take quite a bit of abuse and all that and I can give it out as well quite well but at that time (pause) I just couldn't for some reason".

The meaning I make of these extracts is that Craig is describing a process of unfavourable social comparison with peers. There is some evidence to suggest that social comparison, a key issue in adolescence, can have an impact of eating. For example, Morrison et al (2003; 2004) found that people restrict their eating when they compare themselves to those they perceive as more successful, or in response to fears about loss of status. Gatward (2007) discussed this further from an evolutionary perspective and suggested that dietary restriction can be explained using the concept of 'social attention holding power' and the need to belong. She argued this relates to an attempt to maintain status and belonging with a peer group that is perceived as threatening. For Kate and Craig their peer status was undermined by the negative evaluations made by their peers. Later in their interviews, both participants discussed the sense of mastery acquired through dietary restriction. However my reflection on their weight and shape manipulation is that it served as an attempt to make them acceptable to their peer group and in doing so, to maintain their self-esteem.

I will now discuss the significance of separation from parents and the potential influence of this on identity-formation and developing anorexia.

4.4(2) Separation from parents: 'Am I ready to go it alone?'

As part of her multifactorial account, Kate also associated the development of her eating disorder with parental separation. She described losing weight on three occasions. Her weight loss was precipitated when separated from her parents. On the first occasion, she was separated from them when she went on a holiday with a friend and her friend's parents. On the second and third occasion, her parents went on holiday without her. At this point her mother noticed Kate had lost weight:

> "My mum and dad went away on holiday again, they went away on holiday in October and I stayed with my relatives. Erm (pause) and that week (pause) for whatever reason things (pause) just got really bad you know? I wasn't keeping any food down without being sick. Err, so I lost a lot of weight that week. When my mum and dad came home I went shopping with my mum actually looking for some dress or something (pause) and that was when she really noticed just how much weight I'd lost".

I wonder whether weight loss and dietary restriction were adopted to help her to manage these episodes of separations from her parents. This possible meaning is partly influenced by other things Kate says later in her interview. For example, she later described how her parents set particular limits based on 'her anorexia', including what they believed she was and was not "well enough" to do. I am curious as to whether Kate adopted an 'illness identity', which then became a useful mechanism in negotiating the division and prioritisation of time between her peer group and parents:

> "Like, in a way I was quite reassured that although I, when I was anorexic I still maintained, I did still have quite a good social life and I was doing stuff that I probably shouldn't of, like I was going out drinking and stuff like that. I think it was like, sometimes it was quite reassuring for my mum and dad to be like "No you can't go out you have to stay in and do your school work." Whereas all my friends like, who had a normal social life, they were all out and stuff. But I had this, like I felt like it was OK to be boring and do that because I wasn't really allowed to go out".

My interpretation of this extract is that Kate was expressing an underlying separation anxiety in moving from parental to peer relationships and the ways in which her

'illness identity' provided a useful way of regulating the distance and separation from parents. From this perspective anorexia might be a mediator of the emotional and social transition from parents to peers. I wonder if Kate may have sought the safety associated with complete dependence on her parents and was prepared to utilise the position of being 'ill' to maintain her childlike dependence on them, or at least ease the transition. Bruch suggested that adolescents often arrive at puberty with an "incomplete sense of separateness" (Bruch, 1985, page 13). Coupled with the development task of gaining independence this may result in the anorexic adolescent utilising his or her body as the medium through which some sense of control and mastery can be experienced.

4.4(3) Mastery efforts: 'Look what I can do'

For Kate, I believe that losing weight and controlling her weight and shape were highly rewarding in the sense of gaining self-mastery and competence. Kate made numerous references to how she felt weight loss significantly improved her confidence:

> "I think I just found something, it became something else I was good at. Err (pause) like I used to love the fact like, a lot (pause) I was at that age where a lot of girls were trying diets and stuff and it used to be like something that was brought up quite a lot over lunchtime or like, just in general. I used to take pride in the fact that I found it really (pause) really easy to lose weight. And, I could hear other girls struggling about it and talking about it and stuff like that and just, like, I used to be able to lose like, goodness knows how much, and I used to love when people used to notice that I'd lost weight. And it just (pause) I dunno (pause) it just gave me a confidence I don't think I would have had otherwise".

From a developmental perspective, my interpretation of her weight loss is twofold. Firstly, it creates a specific identity within her peer group – 'the one that could lose weight when others couldn't'. Secondly, it is a compensatory behaviour to respond to her confidence deficit. Kate made reference to the 'label' of anorexia and how she actually sought to have such a label:

> "I think in a way it was a bit of a comfort, because a think first I like, I probably quite liked having the label of being anorexic. And I think initially I felt like finally I'd lost enough weight to actually be anorexic".

To "be" or "become" anorexic points to the need to establish an identity. For Kate, the label of anorexic was one she was initially comfortable with. When considered in the context of the other stressors in her life at the time, including bullying, increased separation from parents, insecurities about academic success and peer relationships, coupled with a sensitive temperament, it appears that the search for identity may have been a particularly complex and difficult one. Striving to acquire mastery over her weight and shape can be understood in relation to her fluid and somewhat insecure sense of self. I interpret her need to control her weight and shape as a means of acquiring psychological safety by managing anxieties about the range of aspects of life where she perceived little sense of control:

> "Although losing weight did give me confidence I still was insecure. But just without it I would have been really, really insecure. Like that was my little safety net like I used to be able to lose weight".

Returning to Craig, I also consider his struggle with a basic psychosocial conflict surrounding identity. At his age, much of his self-evaluation would probably be based on the evaluations made about him by peers. To consider oneself "fat" as he did is often a short hand for a range of personal deficits: being unattractive; lacking self-control; being weak and defenceless. He went on to discuss how losing weight was a process that felt "good" and associated with personal "achievement".

Reflecting on the adverse experience of being bullied, and the challenges this may have placed on his sense of self, it is possible that by losing weight he is seeking to create a greater degree of control in an otherwise chaotic and frightening context, one he perceived as lacking in control. When Craig discussed the process of re-feeding and weight restoration in hospital, he referred to a pervasive desire to restrict his dietary intake. If food equals "getting fat" and fat means being defective in some way, then it is entirely understandable why food would be experienced as highly aversive. Conversely, if dietary restraint equals "being thin" and thin means being acceptable and attractive to self and others, then it is equally understandable that dietary restraint would be experienced as highly rewarding:

> "It made me feel better and just that I did something, had achieved something".

By describing weight loss as an achievement, he is creating a meaning about weight loss: what the weight loss might convey about him as an individual. For Craig, I believe the experience of losing weight was an attempt to transform himself into someone more acceptable to others, and in doing so was an attempt to create a more competent and confident self-identity.

4.4(4) Identity summary

Of the twelve participants recruited to take part in the study, one was in his late teens, six were in their twenties, two were in their thirties, one was in her forties and one was in her fifties at the time of data collection. All had developed anorexia within their teenage years. However, Craig and Kate had recovered in the last 18 months to 2 years. Their responses to questions relating to the development of anorexia described and explored a range of psychosocial issues such as experiences of being evaluated and judged by peers, episodes of separation from parents and negotiating the change in priority from kinship to friendship networks. They also discussed attempts to manage the emotional aspect of this significant development stage and to experience the self as competent in the face of increasing independence.

Reflecting on my clinical experience as well as the responses of these participants, I am aware of the centrality of identity-formation for many of the people with whom I work. In particular, when working with adolescents in an inpatient setting, many raise similar issues to those expressed by Kate and Craig. Questions such as "Who am I?" "With whom do I want to spend my time?", "What am I interested in/What do I want to do?" are posed regularly when young people reflect both on being ill and making a recovery.

Indeed, participants' perceptions and beliefs about the development of their eating disorder influenced how they then perceived the notion of recovery: whether it is something possible, achievable and/or desirable. Moreover, participants described being ready and able to recover only when the issues that contributed to the development of anorexia had been attended to, both within and outside of treatment and psychotherapy. These issues will be explored fully in Chapter Five.

4.5 Conclusions on Developing Anorexia

Findings from this chapter explore participants' experiences of developing anorexia and their associated beliefs, perceptions and understandings. These reflect their sense-making about possible causal and precipitating factors in acquiring difficulties with food, eating, weight and shape. They also illuminate the complex and multi-determined nature of developing anorexia and the unique interplay of factors that can result in the development and maintenance of serious eating disorders.

These findings are consistent with the hypothesis that anorexia has a multi-factorial aetiology (for example, see Lask et al, 2000). Interestingly, all participants define anorexia as a mental health difficulty. Nonetheless, they were unanimous in their view that anorexia developed within the context of a range of problematic life experiences, spanning attachment difficulties, traumatic incidents and issues with personal identity. It did not 'arrive out of nowhere'.

I wish to briefly revisit the hermeneutic cycle of moving between specific extracts of transcript and the narrative as a whole. To separate the superordinate themes of Attachment, Trauma and Identity signifies a differentiation of them, highlighting what may be distinct about each and distinguishes one from the other. However, the coding process creates a somewhat arbitrary distinction, which fails to fully recognise the interconnectedness of these themes. Within each experiential account, I was able to see relationships *between* each theme. For example, the way in which attachment difficulties may render a child more vulnerable to traumatic experiences such as abuse and neglect. I would suggest that there are often overlaps and connections between the three superordinate themes, where one issue can mediate or moderate the other. While the organisation and presentation of the data requires categorisation, these themes rarely stand alone.

Firstly, eight participants narrated problematic family issues as important factors surrounding the onset of their eating disorder. These included experiences of low levels of parental responsiveness and availability, parental/familial mental ill-health and

personality difficulties and problems with the marital relationship. I interpret that these lived experiences are connected by the superordinate theme of Attachment.

These findings share similarities with a number of studies mentioned in Chapter Two, in particular, those that explore the relationship between anorexia and attachment difficulties (O'Kearney, 1996; Ward et al, 2000), the relationship between the development of anorexia and low maternal care and high control (Swanson et al, 2009), significantly higher incidence of unresolved loss or trauma in mothers of suffers of anorexia (Ijzendoorn et al, 1996), mental ill-health in either parent (Ward and Gowers, 2003) and narcissistic or dramatic-erratic personality traits in fathers of girls with eating difficulties (Brinton et al, 2005; Steiger et al, 1996).

However, hypotheses that families and family issues are proximal precipitants to the onset of anorexia are challenged by other researchers/clinicians (for example, see Le Grange et al, 2010, in *2.3(2)*) who argued that families should be regarded as part of the solution in the experience of anorexia and not part of the problem. It is important from an ethical perspective that family members of people who suffer with eating disorders are not mistakenly blamed for the causation of the eating disorder. However, it seems equally unethical to reject the personal accounts of those who possess clear meanings about the development of anorexia and the ways in which those meanings connect with problematic experiences involving family members.

Instead of oscillating between the debates viewing families from a deficit perspective or as a resource for recovery, I prefer the suggestion of Cook-Darzens et al (2005), which proposed that families with a member suffering from anorexia present a wide range of functioning with "healthy families in crisis at one extreme to very dysfunctional families with long-standing disturbances at the other extreme" (page 230). This position fits both with my clinical experience as a psychotherapist working within the field of eating disorders and my experience as a researcher with this study. Therefore, the families of Leah (who was sexually abused by her father) and Rosie (who was almost blinded in a physical assault by her father) exemplify those located at the most extreme level of disturbance. By contrast, the families of Craig and Kate may reflect a system under the stress of illness, but which was otherwise supportive and nurturing.

Secondly, seven participants narrated a variety of adverse life experiences prior to the onset of the development of anorexia. These included sexual, physical and emotional abuse as well as other forms of personal losses. I interpret that these lived experiences are connected by the superordinate theme of Trauma.

These findings also share similarities with a range of studies discussed in Chapter Two. For example, those which found that sufferers had experienced a major difficulty in the year prior to the onset of anorexia (Brown and Harris, 1978), the most common serious life events concerned close relationships with family, with more troubling events concerning a range of sexual issues (Schmidt et al, 1997). There are studies which propose a small correlation between anorexia and the experience of sexual abuse (Wonderlich et al,1997; Rind et al 1998; Smolak and Murnen, 2002) and childhood emotional abuse, including physical and emotional neglect (Kent and Waller, 2000; Mazzeo and Espelage, 2002). Some researchers caution against the association between sexual abuse and anorexia, arguing that sexual abuse is a risk factor for developing a range of mental health difficulties, not specifically anorexia. Nonetheless, some studies have explored the possible mediating relationship between the two and have suggested that shame, dissociation, impulse control, anxiety, substance use, negative cognitions and mood instability contribute to the use of unusual, chaotic or restrictive eating patterns aimed at regulating emotions, managing distress and negotiating interpersonal relationships (Andrews, 1997; Kent and Waller, 2000; Murray and Waller, 2002; Wonderlich et al, 2001).

Reflecting on my own experience as a psychotherapist in a specialist eating disorder setting, a significant number of the people with whom I work have experienced a range of traumatic experiences, often of a sexual nature. In light of the fact that four out of twelve participants in this study were sexually abused and seven experienced some form of adverse life experience, leads me to believe that there are mediating relationships which can helpfully explain why anorexia emerges at a particular time in the sufferer's life and can hold important meanings for the sufferer.

Thirdly, two participants narrated difficulties with peer relationships, the process of growing up and becoming increasingly independent from parents. I interpret that

these lived experiences are connected by the superordinate theme of Identity.

These subjective accounts are consistent with some of the literature, particularly that which explores the developmental challenges of identity formation during teenage years and the ways in which anorexia can be deployed to negotiate such complex life transitions (Bruch, 1985; Crisp, 1980). These authors argued that the central difficulty for the anorexia sufferer to be a problematic self identity. This coupled with the emergent development task of gaining independence results in the sufferer utilising their body as the medium to experience some sense of control and mastery. In addition, high levels of social comparison, low self-esteem and internalisation of a thin-ideal may render some people more vulnerable to developing eating difficulties (Stice et al 1994; Blowers et al 2003), particularly when making comparisons with models and peers (Cattarin et al, 2000; Groesz et al, 2002; Tiggeman and McGill, 2004; Engeln-Maddox; 2005, Grabe et al, 2008). The issue of peer comparison was important for these participants who seemed to judge themselves unfavourably in comparison to friends and others in their peer group.

A discussion of my findings in relation to other qualitative studies which explore subjective understandings of developing anorexia will be discussed in Chapter Seven.

In conclusion, in this chapter, I have illustrated that participants have clear beliefs and understandings about the development of anorexia and possible causes from a subjective perspective.

Participants' responses fit more closely with a psychosocial construction of their illness, rather than a biological or medical formulation, without relationship, relevance or meaning within the participant's life. This may reflect the fact that all participants recruited into this study have experience of psychological therapy as part of their treatment. Moreover, participants perceive that psychotherapy has to a greater or lesser extent contributed to their recovery process. In other words, the data collected from these participants does not represent a 'lay person's view' on developing and recovering from anorexia. Rather, they offer a mix or integration of both socially constructed and psychologically formulated assumptions about illness and recovery, developed and reworked over time.

In summary, participants' perceptions of developing anorexia are influenced by the experience of psychotherapy. Moreover, while different psychotherapeutic modalities undertake psychological formulation in different ways, each broadly seeks to identify predisposing, precipitating and perpetuating factors. It is impossible to know how each participant's views on developing anorexia might have differed had they not received psychological therapy. My assumption however, is that this will have influenced their subjective meanings in particular and significant ways.

In the next chapter exploring recovery, I will review how subjective meanings relate the experience and process of recovery.

5 Mapping recovery from anorexia

5.1 Introduction

One of the principal aims of this research is to further understand the role of psychotherapy in recovery from anorexia by examining subjective accounts of people who have suffered from anorexia and accessed psychotherapy to aid their recovery process. Implicit within this endeavour is the assumption that recovery from anorexia does not rely solely on treatment experiences, including psychological therapy. These can be broadly defined as the "therapeutic factors" pertinent to recovery. Therapeutic factors may include the techniques unique to particular therapeutic approaches, the portion of improvement that results from the client's knowledge that they are in treatment (the placebo effect), or the common factors found in a variety of therapies regardless of the therapist's orientation.

In addition to "therapeutic factors", recovery from anorexia may also be supported by a range of factors that exist and operate outside of formal treatment. These "extratherapeutic factors" are defined as:

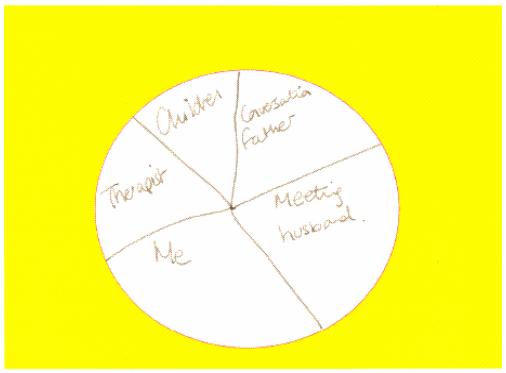
> those that are part of the client, (such as ego strength and other homeostatic mechanisms) and part of the environment (such as fortuitous events, social support) that aid recovery regardless of participation in therapy (Norcross and Goldfried, 1986, page 97).

There is some psychotherapy research that concludes that a substantial number of people improve or achieve "spontaneous remission" without formal psychological intervention (for example, Lambert, 1976; Bergin and Lambert, 1978, Rachman and Wilson, 1980). There are also a limited number of studies exploring recovery from anorexia from a sufferer's perspective, which highlighted a range of important variables outside of treatment (see Table 2). It is this area I wanted to explore further within this study.

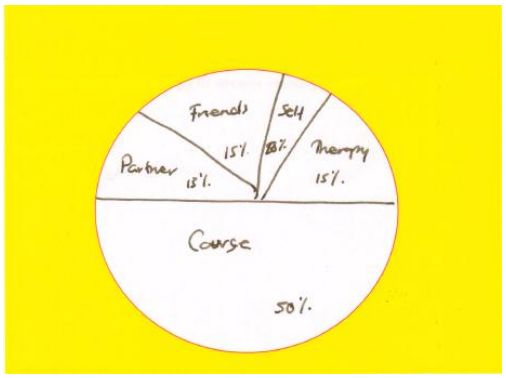
During individual interviews, participants were asked what had helped them with recovery. They were also invited to complete a Recovery chart, which asked them to define the various important factors that contributed to their recovery. Participants were also asked to visually represent the relative contribution of each of these factors by dividing their chart into sections and giving it a percentage value if the participant chose to. Participants' Recovery charts are illustrated next.

Figure 2: Recovery charts

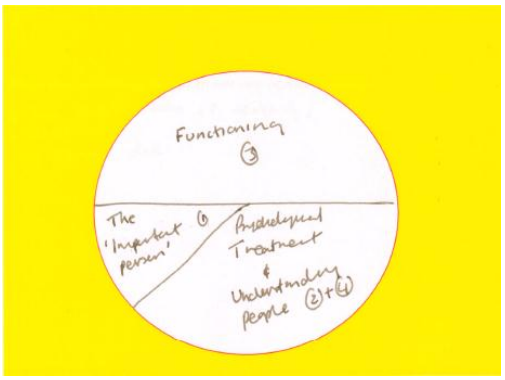
Ailsa



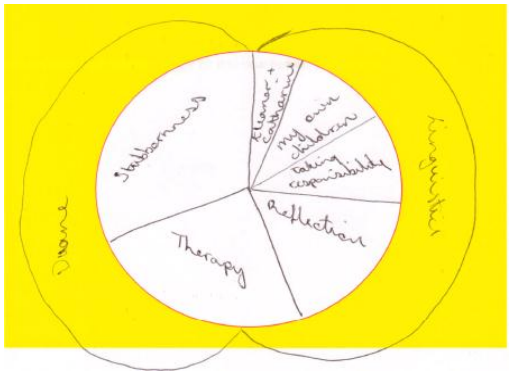
Nadia



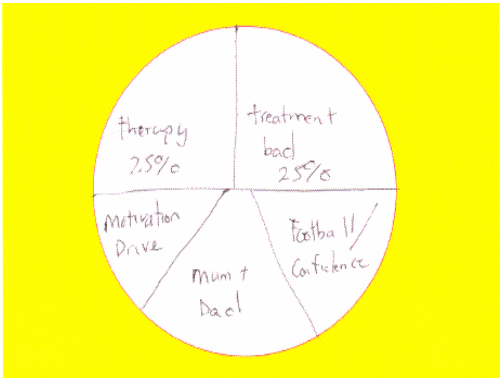
Bethany



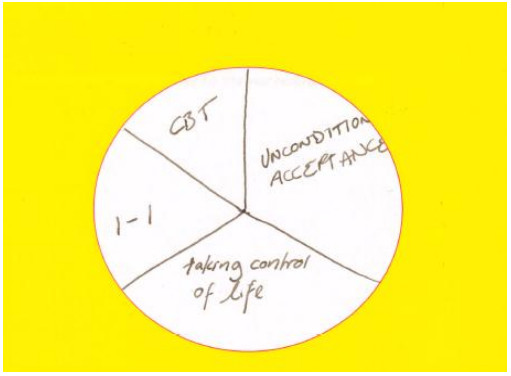
Pamela



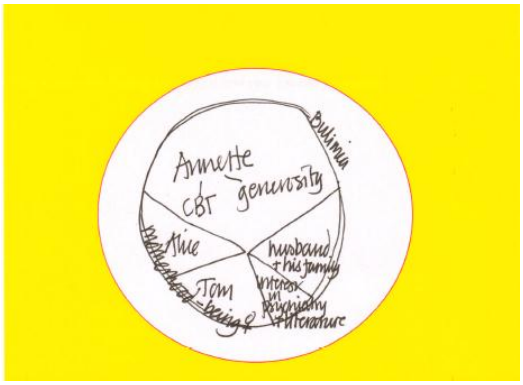
Craig



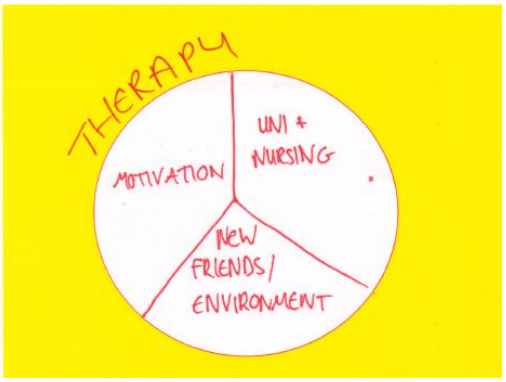
Caitlin



Janice

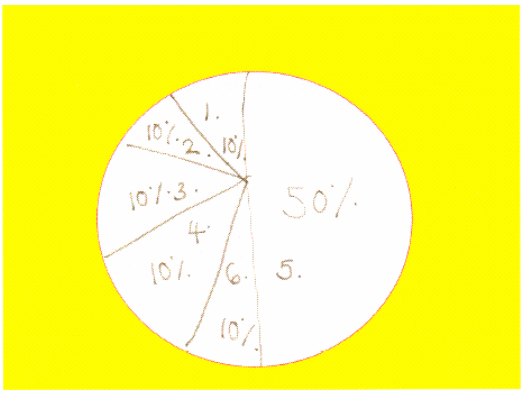


Kate

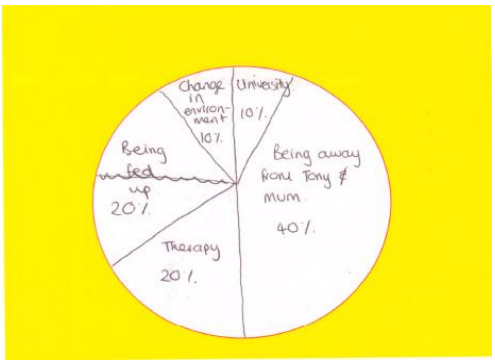


Leah

Anna



Rosie



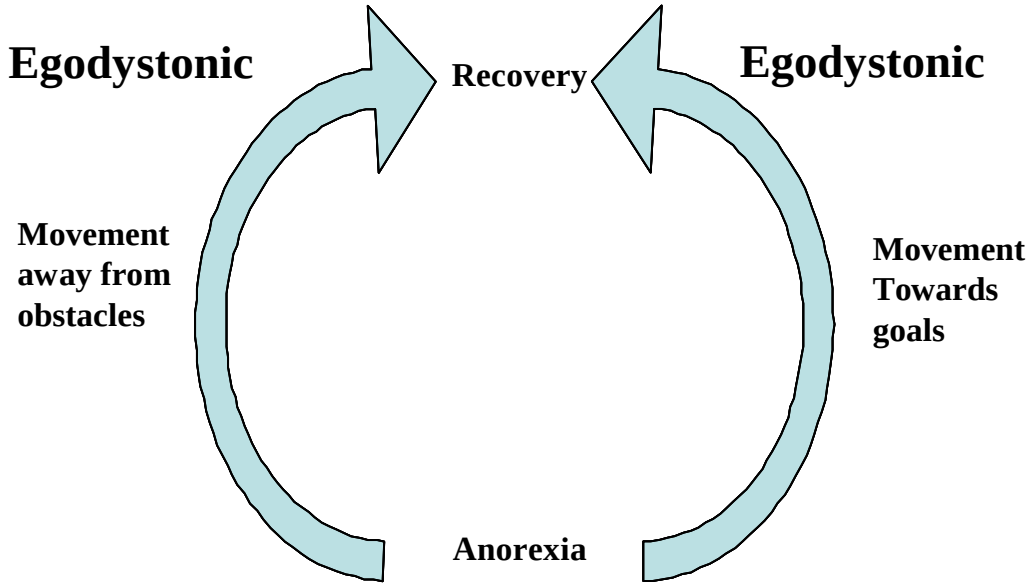
A total of 112 principal statements made about recovery were recorded and filed in NVIVO. Following data analysis, participants' statements were divided into two related but distinct superordinate themes or categories. The first related to definitions of recovery and the second to factors that supported recovery. Definitions of recovery involved each participant's subjective sense-making about what constitutes recovery from anorexia and the meaning they made about recovery as a process. The factors

that supported recovery related to the various components that influenced their readiness to change and subsequent recovery process.

Returning to definitions of recovery, participants shared beliefs and perspectives about their own subjective process of recovery, as well as more general philosophical positions about recovery from anorexia. My interpretation of the narrative data identified two particular genres: one defining recovery as an achievable completion point, signalling the *end of illness;* and the other defining recovery as an on-going process concerned more with the *management of* anorexia than the elimination of it. The former definitions heard participants emphasise the volitional element of anorexia, essentially defining anorexia as a condition that can be altered by personal choice on the part of the sufferer. The latter definitions expressed participants' enduring vulnerability to anorexia, precipitated at times of stress and difficulty. These descriptions of anorexia are more akin to constructions of mental illness as an enduring condition, referring to processes such as rebound, remission and relapse of symptoms.

In terms of factors supporting recovery, with the exception of one person (Leah) for whom therapy alone is identified as the mechanism for change, all other participants said a range of important factors had contributed to their recovery process. These included both extratherapeutic and therapeutic factors. The therapeutic factors will be examined in detail in the Chapter Six. The extratherapeutic factors will be explored in this chapter and from my interpretation of the data, span a range of examples that express recovery as either a movement *away from* the aversive or egodystonic aspects of anorexia or a *movement towards* positive, personal meaningful goals or egosyntonic aspects of being well. The relationship and interaction between the perceived advantages and disadvantages of anorexia and participants' motivation to change is a key theme. This has been categorised as the Pros and cons of change and is represented diagrammatically below in Figure 2.

Figure 3: Pros and cons of change



5.2 Superordinate Theme 1: Definitions of recovery

5.2(1) The researcher's definition of recovery

There is no consensus regarding a definition of recovery from anorexia (e.g. Herzog et al, 1993; Fitcher et al, 2003; Steinhausen, 2002; Walsh, 2008; Bardone-Cone et al, 2009). Part of this study's design involved establishing a working definition of recovery to create a baseline across participants and establish inclusion and exclusion criteria.

In Chapter One and Three, I made explicit the influences that shape my conceptualisation of anorexia and recovery. I subscribe both to a multi-factorial aetiology of anorexia and am professionally influenced by particular psychiatric and psychological treatment approaches originating from a western medical model of mental illness. This includes holding the view that weight restoration is an essential element of recovery. I also believe that recovery is not merely the absence of physical or behavioural symptoms, but includes a degree of cognitive and affective change that frees the sufferer from a relentless fear of weight gain and preoccupation with weight and shape. This does not mean people who have recovered may never have negative thoughts about weight and shape; it is the issue of degree that is significant. The

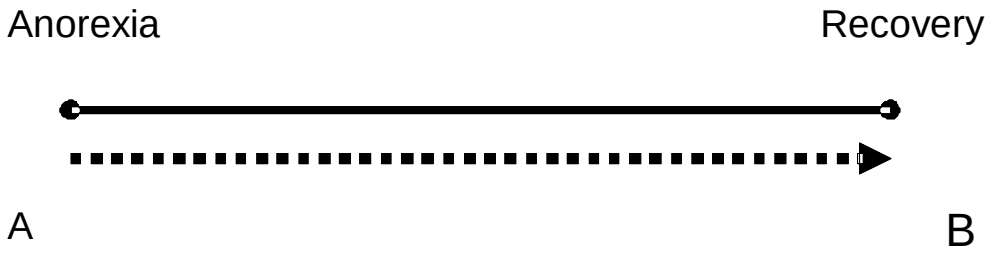
level of concern operates on a continuum, with the most severe and enduring weight and shape concerns leading to significant impairment in physical, psychological and social functioning.

I adopted Bardone-Cone et al's (2010) suggested conceptualisation of recovery, which includes improvement in physical, behavioural and psychological indices. Therefore, I decided to assess participants across the three indices, using the Eating Disorder Examination-EDE 12 (Fairburn and Berglin, 1993).

5.2(2) Participants' definitions of recovery: Journeys and Destinations

Participants described two genres of recovery. The first genre articulated recovery as a final destination, a point of resolution. Within these accounts, the descriptions of recovery were complete and narrate a self that is transformed from 'ill' to 'well'. They were characterised by the flow from past, present to future and located the experience of anorexia in past tense. Such definitions of recovery were told in a temporal structure that affords the reader the opportunity to understand the factors that signpost personally meaningful change, moments or episodes of transformation and represent and re-tell the consistent message of anorexia as "over". These were narratives located in time, developing anorexia and recovery were narrated in past tense, historical accounts that the participant was separated from by time. During the extracts to follow, time and temporality themes will be highlighted and discussed. This genre of recovery is depicted diagrammatically in Figure 3 below.

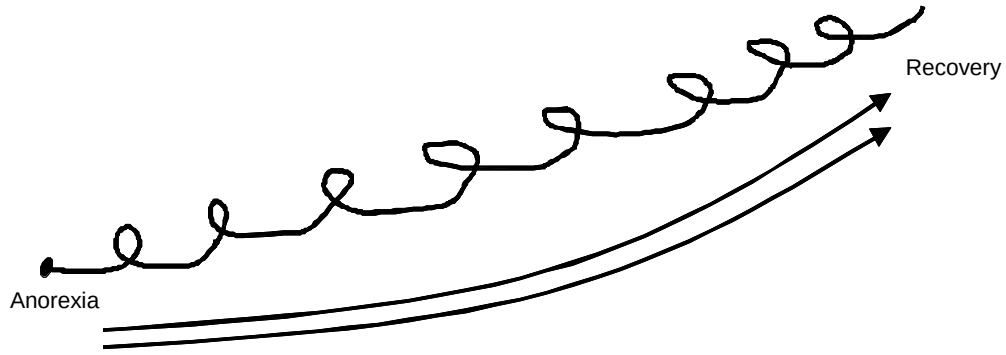
Figure 4: Recovery as a Destination



The second genre articulated recovery as an on-going journey. Within these accounts, descriptions were incomplete and narrated a somewhat ambivalent self that

continues to live with the ebb and flow of anorexia through the continued re-experiencing of symptoms. There was less expression of transformation and more of increased insight and self-awareness into factors that may trigger anorexia-supporting cognitions, affects and behaviours and how the narrator navigated through such episodes. Within this genre of recovery, anorexia remained in the present tense and participants queried if there was a destination free from it. These are narratives located in space, where the participant travels through this ebb and flow and continues to cycle back and forth between triggers, action urges and reclaiming control over behaviours. This genre of recovery is depicted diagrammatically in Figure 4 below.

Figure 5: recovery as a Journeying



Janice eloquently expressed these dual possibilities on the process of recovery:

> "Well it has to be a process, a thing like the air you breathe or the water you're swimming in. In one sense, and that's recovery as a verb. But there's also recovery in the sense of the destination and that can't be underestimated. The idea of recovery as an absence of pathology is equally philosophically valid. Unless you can get to the place where you've shaken it off, particularly when you've been completely riddled with it. If there's a little germ mite, it will multiply again. So unless you've been to a place where you banish it completely, it's not the same kind of recovery. So I would say recovery is something you're moving forward with, towards a particular state, or it's something where you've reached that particular state".

As well as expressing dual possibilities, what Janice referred to as the place where anorexia is "banished" or where there is a "continuing push", she employed spatial

metaphors to describe anorexia as "a destination", "getting to a place", "you're moving forward" towards "a particular state". It is as though recovery involves traversing a particular landscape, an illness landscape.

Interestingly, with the exception of Ailsa, all of the other participants' definitions of recovery can be located within either the journey or destination metaphor. Ailsa's description of recovery is complex and will be discussed later in the chapter.

5.2(2) (a) Recovery as Destination

For Anna, Caitlin, Janice, Craig, and Bethany recovery was defined as a destination. They described arriving at a new place, which signalled the end of their illness. Of striking significance was the way in which the issue of volition emerged from these descriptions of recovery. For example, the use of language in these recovery descriptions implies the sense of *active choice* the participant has. It is possible that these participants conceptualised anorexia as a strategy or solution to other life difficulties. It is context-dependent and has a particular function and meaning for the sufferer. In these descriptions, participants were cast as active agents in their life, able and capable of making choices about whether or not to maintain anorexia. This is highly significant when considering the superordinate themes of Attachment, Trauma and Identity explored in Chapter Four, and in particular, the way in which the development of anorexia was generally perceived as a reaction or response to difficulties related to the three superordinate themes.

For the five participants that defined their recovery as a destination and an experience that is now in the past, I identified two dominant sub-themes from their narratives. The first relates to the experience and expression of Choosing and the second to Belonging.

The sub-theme of Choosing referred to the possibility that the participants' construction of their illness experience would inform and dictate the trajectory of it. It related to the idea that deciding the illness could end subsequently enabled that to happen. The sub-theme of Belonging related to the possibility that participants elected to create an anti-identity or egodystonic construction of anorexia as a means of

distancing and separating themselves from it. Whether by choice or no longer feeling they belonged within anorexia, these sub-themes helped participants perceive their recovery as an ending of illness and the beginning of something new.

5.2(2) (a) (1) Choosing

Anna's description of recovery placed choice at the heart of the process. In the following extract she discusses a process of repeatedly choosing recovery and uses the word choice ten times in the following extract:

> "I'm recovered. And if there was circumstances which were ever to arrive and I knew I was having anorexic thoughts, I would know to go and see J. But er, I don't think I will. Because I'm choosing not to go down that road, because to a certain extent, when you're getting better from anorexia it's about choices. And don't get me wrong, before I had children I was very ill, and I wouldn't have cared. Before I had C and R (participant's children), I know that when I was very, very ill, they would have been, the Anorexia would have been before them. So for me, not having anorexia again isn't about C and R, it's about me and I'm choosing not to have it. But when you're getting better it's when you realise you're making these choices through life. You don't choose to be anorexic but you choose not to have the juice, you choose not to have the chocolate, and when you're getting better you choose to have extra chips with your meal, and you choose not to have 5 laxatives, so I choose not to have that".

She explicitly stated that recovery is *not* because of her children. This reminds me of the significant factors for Anna in developing anorexia and specifically the trauma associated with terminating a pregnancy and perceived family pressure to do so. The underlying meaning may be the perceived lack of personal control resulting from a traumatic reaction to the termination. This then led to a choice to utilise dietary restraint and other weight loss strategies as a method to reclaim control. From this perspective, recovery is about *choosing* another means to acquire personal control.

The sub-theme of choice is also evidenced when Caitlin described that she was not "tempted to go back". In describing "temptation", I think Caitlin was alluding to the strong volitional element, either in making a recovery or in relapsing. Like Anna there is a link between anorexia as a means of acquiring control:

> "And I still had, I must still have had times when it was easier to go back into the behaviour of (pause) things that I found would make me feel more in control like not eating or going running or whatever. But I wasn't tempted to go back to (pause) being ill again in the way that I was, definitely not".

For Craig, the sub-theme of choice is evidenced when he suggested he had "drawn a line under it". He went on to describe how the risk of relapsing or returning to anorexia is increased if he decides to perceive it as an enduring illness:

> "I've drawn a line under it. And like now, you don't know what's going to happen in the future, but I'm not, I don't, it's not that (pause) for me I don't believe that once I've had it I've always got it, I don't believe that cause that's when you think oh you're letting yourself in for a fall here."

In other word, Craig's perception of recovery was that if one chooses to define anorexia as an enduring illness then it will be. Conversely, if one selects a definition that includes the possibility of 'cure' (by whatever means), then the individual is more likely to experience life without it.

With all of these extracts, spatial metaphors were employed, whether it is "not going down that road", "not going back" and heading for "a fall". The image of participants traversing an illness landscape recurred repeatedly for me during analysis of their recovery narratives. Linking their recovery narratives to their illness narratives, the issue of choice is potentially significant. Anna did not think she had a valid choice when she discovered she was pregnant. Perhaps it was particularly meaningful that she herself decided when to end her illness. Similarly, Caitlin talked about feeling "unheard" within her family. She perceived that important decisions about her schooling and future career were made without her input. In this context, her autonomous decision-making and choice had an additional meaning. Finally, Craig did not choose to be overweight or have facial acne. He did not choose to be bullied and marginalised from peers. He did not choose to be removed from school and be admitted to hospital. All of these experiences were perceived as "out of" his control. The decision to recover and improve his life was his own and that seems to be of importance.

5.2(2) (a) (2) Belonging

For other participants, recovery was discussed from a position of no longer "belonging" with anorexia and illness. The sub-theme of Belonging was conveyed when Bethany described herself as being in "another world" from anorexia. She told me that this is a world that she longer belongs to:

> "Yeah, I just feel that my feet are so squarely in this other world that I can't be in the other one, I can see it, erm, and I can visit but I, and by visit I mean I can be around other people who are in the grips of it but I can't stay there, I don't belong there".

She then said there may be a destination beyond recovery. She pointed out that the term 'recovery' is inextricably linked to the term 'illness'. She no longer wanted to define herself as 'recovered' as this indirectly defines her in relation to an illness:

> "In fact, I would go to the stage beyond recovery, which is (pause) that by saying I am recovered, I am still defining myself by an illness. Erm, and I am defined by the absence of an illness. Erm, by everything else, which is to me being recovered, is where I was until April and now it's something beyond that".

Bethany wished to locate her self-identity beyond the 'destination of' recovery as she now 'belongs' somewhere else. I am reminded of the attachment issues raised in her description of developing anorexia. These included not belonging in the community where the family lived and struggling to have an affective experience of belonging with (having a secure attachment to) her mother.

This leads me to create a hypothesis that for Bethany the role of belonging in recovery links directly to having found a means of securing a sense of belonging with other people and things (for example, her therapist, her partner and her university course).

Ailsa also described her sense that she no longer "belongs" with anorexia. She referred to anorexia spatially, as a place where she no longer belongs. Moreover, she added that her sense of alienation from anorexia was reassuring. She was concerned that if she thought of anorexia as a desirable place this might lead to a relapse:

> "It's fairly intangible. It's frustrating. A lot of it is a feeling, it's just a knowledge that I don't belong there anymore and that I can't go back. And a safety in that because I can have a day where, or two, or a week, where it can be really stressful and my eating being affected by that stress, but by the stress not by me. And (pause) and when I'm not stressed anymore I just carry on. And there's no danger anymore, no, there's no threat, there's no fear that it's all gonna (pause) I'm gonna lose my grip on it".

In telling herself that she does not "belong there" with anorexia, she is reminding herself that it is egodystonic and is attempting to create psychic distance from it.

Regardless of the construction used by participants to define and locate themselves as recovered, these accounts are fundamentally describing recovery as *an ending*, the end of the illness story. The placing of events in this sequence and the causal links made about what helps with the recovery process, is a crucial activity in assisting participants to create unique meanings about their illness and recovery experience. Elliott (2005) suggested that endings have a fundamental role in the narrative process since "It is the ending that determines the meaning of the actions and events within the narrative". Beyond the meaning-making process, I would argue the participants that express the perception of recovery as the end of the story are using this process of re-telling the past as a potent method of influencing and changing the future, that is, being without anorexia, constructing life beyond it. McAdams (1993) discussed this process in his discussion of 'Nuclear Episodes' (page 293) within a narrative. He suggested that our remembrance of the past is highly selective and involves significant reconstruction. This subjective process, in which certain events (such as developing anorexia or recovering from it) take on particular meanings over time are utilised as a way of establishing and re-establishing identity vis-a-vis the events in the narrative, 'that was then, this is now, that was me then, this is me now'. Again, spatial metaphors are used in terms of not belonging "to this world", being "beyond" anorexia, within a new experiential territory.

Returning to connect the accounts of recovery with those of developing anorexia, both Bethany and Ailsa narrated difficulties within their family relationships, which I view as an expression of their attachment difficulties. To then describe the importance of *belonging* as part of the recovery process, in my opinion, helps to reinforce the relevance of attachment issues as a subjectively-perceived precipitant to the

development of anorexia. At a basic level, attachment is about creating and sustaining bonds of belonging that persist over time, offering care and protection. Such experiences also inform self-identity. Experiences of belonging (whether to the original attachment figure(s) or to new people and places) offer significant reparative opportunities. It was precisely these types of experiences that supported the possibility of recovery. Based on participants' own meanings of the development of their illness, these opportunities offer restoration and healing of the 'original injury'. This will be considered in more detail when discussing the role of psychotherapies in Chapter Six.

5.2(2) (b) Recovery as Journeying

For Nadia, Rosie, Kate, Emily, Pamela, Leah and Ailsa, recovery from anorexia was defined as a process (although Ailsa paradoxically described it as both an on-going process and a final destination). There was no "the end" within these narratives and these participants questioned the possibility of a state of complete recovery given their enduring experience of anorexia. These accounts described a continued awareness of the presence of anorexia. Based on my interpretations of these extracts, I identified two additional sub-themes. For some participants the subtheme related to anorexia as a constant experience, being 'Always There'. Other participants challenged the concept of complete recovery on the basis of their continued awareness of the factors that may act as a precipitant for relapse, that it 'Might Come Back'.

5.2(2) (b) (1) Might Come Back

Pamela had experienced both recovery and relapse. Ten years after her first episode of anorexia she had a further relapse. She compared anorexia with "catching a cold" to argue that the latter is a more straightforward illness process that can be predicted to result in a complete resolution of symptoms. She narrated her vulnerability of relapse from anorexia, implying that there are different types of illness with different trajectories:

> "It is possible to recover but you always have to be aware that it may come back. I am very wary of that because I've already thought I've recovered once, and it came back. But I am stronger after already recovering once so (pause) I don't think you can say (pause) well it's like catching a cold. You can have it and get rid of it but it can come back

again".

Reflecting on Pamela's perception of recovery and linking this to her perceptions on developing anorexia, I am struck by the overwhelming sense of fragility in many fundamental areas in her life - for example, where she lived, with whom, when she would see her parents and the quality of her relationships with both parents.

If the sub-theme 'Might Come Back' is understood as an expression of anxiety, related to uncertainty about the future based on experiences of inconsistent care-giving in the past, then perhaps Pamela has not yet received sufficient reparative opportunities to restore her confidence in consistent care and ultimately address her underlying anxieties. Another possibility is that she might perceive that she will never receive sufficient reparation to allow full recovery to take place.

5.2(2) (b) (2) Always There

Nadia discussed her recovery process in relation to time. She suggested that she continues to adapt to eating more regularly again:

> "I don't know if it is a recovery or if it is an on-going process, like I was saying now that I've recovered but and still because it was only a short while ago I'm adapting, getting used to the new environment though, it's not that, I don't believe that there's recovery in terms of anorexia and that there's nothing (pause) I was just I feel like I'm still getting used to just being able to wake up and not bother about what I'm having for breakfast".

When she suggested, "I don't believe there's recovery from anorexia and then there's nothing", I immediately recalled her perceptions about developing anorexia and specifically the experience of childhood sexual abuse. Therefore, reflecting on her sense of recovery and specifically her question if there can be "nothing", I associated this with the enduring experience of pain and distress connected with her experience of childhood sexual abuse, something she has never been free of. There isn't "nothing" as she has her memories to live with.

Caitlin suggested that her personality traits - being "controlling" and "perfectionist" resulted in her perception that anorexia persists, albeit in a more dormant or latent way:

> "I don't think that you completely recover. I think you will always think, erm, I'm not saying you're ill forever, but you will always think (pause) be conscious of things, to a degree, more than other people. Like if I go through something really stressful, I have to be aware that I am not cutting back on what I eat and I'm not going running. That is my weak point. Just like an alcoholic will turn to alcohol, I would say that, you know, you're an ex-smoker. You're a non-smoker or an ex-smoker. I think you're an ex-eating disorder subject forever. But I think you can lead a fully normal life and be (pause) I think you can be in remission (laughs). I suppose that sounds really pessimistic cause I know people say, 'yes you can totally recover,' but I'm just skeptical. I think there will always be a part of me that will be controlling and perfectionistic and I think those traits will always be a risk".

When she referred to the need to be "conscious of things", I take this to mean that she reacts to stress in a particular way, aiming to manage stress by adopting mechanisms to perceive oneself to be "in control". Being perfect is the ultimate expression of control. In summary, Caitlin seemed to be suggesting that her basic personality structure remains the same, but the way she manages these aspects of her personality is different.

The concept of recovery was complicated for Kate by our Western socio-cultural context, in which thinness is held as a beauty ideal. Accordingly, many people experience concerns about weight and shape, and engage in dietary restriction and other forms of weight loss/management. So widespread are these practices, Kate suggested they are normalised within her own context, leading her to question the prevalence of body image concern in mainstream society and the extent to which this actually differs from anorexia:

> "On my first year in university I was, more than well on the road to recovery but it probably wasn't until, erm, the second year of university, which was when I was eighteen that I feel I would say I was recovered (pause). But, I don't know, it's really hard because, sometimes I think well do you ever fully recover, really sometimes you do still, and even just a stage sometimes you have, not blips, but I think it's just it's hard because everybody these days are so obsessed with diets and stuff and when I, like sometimes I think "Oh well is that just normal", and you kind of become a bit paranoid".

This is an interesting point. Unlike people who develop difficulties with drugs or alcohol and can decide to abstain from it, a person who has recovered from an eating disorder, an "ex-eating disorder subject" as Caitlin called it, needs to find ways to

establish and maintain a new relationship with food and eating, as well as a new relationship to their body.

Leah also compared anorexia to an addiction:

> "It's like an alcoholic or a drug addict. Not that I'm pigeonholing someone, but I think they are always in recovery. Right? I think they've got to be wary of triggers and the positions that you get yourself in that makes your thinking go back. Because that's what gets me, it's my thinking that gets me. But I can talk myself out of anything. That's not important to me; it's not what I think about every single day. "I'm not going to eat, I'm not going to eat". It's not a big deal anymore, but when I'm stressed or something right shite happens, I cannot eat for a couple of hours when I'm supposed to or I can miss my lunch and then it freaks me right out, so I go and have something to eat. Because I know that "You're doing this again Leah". So I'm aware of what I'm doing now. So it's no (pause) to me it's not a big deal. And I don't think that that will ever get away from me, I don't. I'm comfortable with what I eat, I sit down and eat dinners and I go out for meals and things like that but I just don't think that will ever leave me".

Leah likened anorexia with an addiction and postulated that both require on-going management, rather than ever reaching a point of cure. She described how her thinking style renders her vulnerable to engage in anorexia-supporting behaviours. She went on to describe how she needs to sustain a level of insight to allow her to manage this. Her use of language is also important when she stated, "I just don't think that will ever leave me". Revisiting what Leah said in her account of about developing anorexia, my interpretation is that the trauma of being sexually abused by her father has had such far-reaching consequences for other areas of her life that it has not "left her". Perhaps some experiences are so traumatic that they permanently change us. In the next statement, she talks about "coping" rather than "cure". Again, I understand this as an expression, at least in part, about her experience of child sexual abuse. This is not something that is cured but coped with:

> "Yeah, I'm not gonna cure myself. I'm gonna manage with what I've got. Coping".

5.2(3) Recovery as both Journeying and a Destination

Ailsa's definition of recovery did not fit either with the journey or destination metaphor. In fact, she appeared to suggest that recovery is both. She described a dialectical tension between feeling much better, being "a different person" but moves immediately to the other position of her subjective awareness that anorexia persists:

> "So my first thought is recovery-wise, that I'm almost a different person from who I was, but my second thought is it's always there".

The dialectic almost reached a point of contradiction in the next extract by when she states, "The recovery has been but I'm still recovering":

> "From about the age of eleven that was part of who I am. So, at age forty or almost forty, the recovery has been but I'm still recovering. But it's still part of who I am cos I've been through it".

She appeared to be suggesting recovery is *both* a destination and a journey. The other part of the extract illuminates the centrality of identity. She seemed to believe that because she has suffered from anorexia for some 30 years and it has been present throughout most of her developmental process, it is difficult to perceive it as an 'illness', a type of unexpected, de-contextualised happening, like "catching the cold" as Pamela discussed.

If anorexia is subjectively understood and experienced as a part of the self then it is important to allow sufferers to find their own definitions of recovery and wellbeing. The reality of recovery is inherently complex. As Roberts and Wolfson (2004) suggested:

> Recovery is neither about an unrealistic hope of magical transformation, nor about the impossible prospect of returning to whatever precedes illness. Instead it is an open-ended and cautiously optimistic process of sketching out a path forward and developing hope for a more satisfactory life alongside whatever remains of the illness (page 44).

From this perspective, it seems both permissible and important to value Ailsa's definition of recovery as both journey and destination.

Having discussed participants' definitions of recovery, I will now turn to the second superordinate theme: the factors that support recovery.

5.3 Superordinate theme 2: Factors that Support Recovery Extratherapeutic Factors

As demonstrated visually in the Recovery charts, participants mentioned a range of factors that contributed towards their recovery. These include both therapeutic and extratherapeutic factors. Before sharing findings, it is important to emphasise the importance of the relationship and interaction between various extratherapeutic factors and each participant's overall motivation to recover.

Readiness to recover from anorexia has become an important marker for change (Ametller et al, 2005, Rushford, 2006). Research has tended to focus on adaptations of the stages of change questionnaires (SCQ) (Prochaska et al, 1992), initially developed from the trans-theoretical model of motivation for change. In anorexia, the stages have included precontemplation (failing to recognise a problem, not considering change), contemplation (thinking about making changes), preparation (preparing to make changes), action (working on recovery) and maintenance of change (working to maintain changes), (Reiger et al, 2000; Ward et al, 1996).

A variety of instruments have been developed to assess readiness to recover from eating disorders - for example, the decisional balance (Cockell et al, 2002; Geller et al, 2001; Mazure et al, 1994; Reiger et al, 2000, Vitousek et al, 1995). Efforts have been made to identify the correlates (and possible determinants) of readiness to change in people with eating disorders and in particular the perceived negative aspects of having an eating disorder increase as motivation to change increases. Moreover, higher levels of readiness to recover are associated with higher self-efficacy regarding overcoming anorexic symptoms (Rieger et al, 2002). Vitousek et al (1998) theorised that motivation to recover from eating disorders is multi-determined, with an individual's level of motivation fluctuating across the various symptoms of the disorder. Motivation to change is likely to be higher in relation to the more subjectively distressing symptoms of the disorder - for example, mood difficulties and food

preoccupations. Motivation to change is likely to be lower for the positively valued features - for example, low weight or the affect associated with dietary restriction (Janice said she felt "gloriously in control" when restricting her dietary intake).

Participants describe two distinct processes which impacted on their readiness to change and motivation to recover from anorexia. For some, these processes were associated with an increased awareness of the costs of anorexia and the major personal disadvantages for the individual. Recovery for these participants involved *moving away* from the egodysnotic aspects of anorexia. For other participants, recovery was associated with an increased awareness of the perceived advantages of getting better and the ways this may improve or enrich their lives. Recovery for these participants involved *moving towards* the egosyntonic aspects of wellness.

5.3(1) Moving Away From

Participants described a range of aversive aspects of anorexia. These aversive aspects contributed to a desire for change and a readiness to recover. The Moving Away (from anorexia) process is influenced by a number of factors. These include changes in perception: viewing oneself less favourably with anorexia (Ailsa); perceiving that anorexia would transfer into a frightening experience of bulimia (Janice) or reframing anorexia as an enemy rather than a friend (Anna). The Moving Away process also includes concerns about the negative impact of anorexia on important relationships (Bethany and Pamela), and concerns about potential losses that may occur as a result of maintaining anorexia (Rosie and Janice). It also involves a literal and physical moving away from abusive relationships (Rosie).

As well as discussing these examples in more detail, I will review them in relation participants' earlier descriptions of developing anorexia. Indeed, when exploring participants' accounts of illness and recovery together, each offers new and illuminating meanings about each; how beliefs about illness might inform accounts of recovery and vice versa.

5.3(1) (a) Negative Judgements: Seeing myself as others see me

Returning to changing perception, Ailsa described identifying less and less with other sufferers. She talked about starting to believe that other sufferers in her treatment cohort were "missing the point":

> "I'll be honest. I think I mentioned before about looking at other people, this is going to sound awful. But I would look at other people and I remember thinking 'I don't wanna be that age and be like that'. And I think, as awful as this sounds, when we had group sessions, I would realise then I wasn't in the same place as other people and could see the bigger picture, that was passing them by completely, like the fact that M (therapist) was overweight and this, and conversations that were had by other people in the room when she was out of the room about it. I was thinking you know, missing the point completely".

The egodystonic element appears to stem from an anxiety that others might think that Ailsa is equally "missing the point". This shift in identification may point to a change in her identity, moving away from anorexia and people with anorexia to non-sufferers, including her therapist. This capacity to see herself through the eyes of another seems to have been important in helping Ailsa to reflect on herself from a new perspective and one which made the status quo appear undesirable.

Reflecting further on her need to imagine how other people thought of her, I also connect this to her account of developing anorexia and, in particular, the way she was preoccupied by being "the perfect child", with schoolwork, as a friend and daughter and with her weight and shape. In other words, her sensitivity towards self-scrutiny may have persisted and ultimately influenced her readiness to recover.

5.3(1) (b) Another type of eating problem: Bulimia

For Janice, anorexia did not become aversive; in fact she referred to it as a "serene circle":

> "One thing that definitely helped me recover was having bulimia so if I had stayed anorexic, I might, like my sister, not have recovered now. So, in many ways, I'm very grateful to the bulimia, cos it sort of, having been in the serene circle of anorexia, it was one of the most awful experiences that I couldn't abide".

Instead, her eating disorder changed and she developed bulimia. This resulted in weight gain, binging and purging behaviours, the perception of being out of control and high levels of self-disgust.

Throughout Janice's account of developing anorexia, she narrated significant difficulties with core low self-esteem and continued efforts to alter and change herself to experience acceptance and care from her parents. Based on her descriptions of anorexia and bulimia, it would appear that anorexia was perceived as a vehicle for self-transformation, whereas bulimia was perceived as a vehicle for self-denigration. If that is correct, it would follow that bulimia was experienced as highly aversive and something she was compelled to change.

5.3(1) (c) Anorexia's tightening grip

For Anna, recovery involved a shift in her perception about the deployment of anorexia to achieve personal control. Over time, Anna began to perceive anorexia as *controlling her* rather than it being something firmly within her own control:

> "I realised that I needed help with my stuff, and I needed help with my control. It wasn't even that I thought I was dying, it wasn't even that I thought, I mean, 'Oh my God what's wrong with me?' It was like, I thought that I was in control of all of that, and here really I'm not, It's in control of me. So (pause) and that was the thing. That made me devastated. Absolutely devastated".

This extract reminded me of her account of developing anorexia and specifically the central significance of having a termination. With her acute sensitivity to the perception of "being controlled" following the termination of her pregnancy, it is significant that if anorexia came to be experienced as outside her own locus of control, it would simultaneously become aversive. This shift in perspective seemed to alter Anna's relationship with anorexia and ultimately contributed to her wish to recover.

5.3(1) (d) Things that risk "Us"

Anorexia had a negative impact on some participants' personal relationships. Bethany talked about the possible loss of her best friend who was finding it

increasingly difficult to support her with the eating disorder. This potential loss was sufficiently aversive to allow her to contemplate change in a more serious way:

> "She said that she couldn't talk to me on the phone because it was just too difficult for her, erm, so two of my main sources of support, besides D (partner), were gone in the space of a week or two. It made me realise that actually if I didn't do something to get myself out of this, I wasn't going to get out of it".

Similarly, for Pamela, the loss of a partner was a key trigger for her recovery. She described her belief that he had ended their relationship because of the stress that anorexia placed upon them as a couple:

> "But I realised that, you know, I had this problem and I knew I had to recover not just for me but my family and people around me. With my partner leaving it made things much harder, but that's when I knew I had to".

Given Pamela and Bethany's accounts of developing anorexia, the potential or actual loss of significant relationships (attachment figures) may have particular types of meanings. For example, Pamela talked about being permitted to live alone from the age of 14 years. For me, the function of her anorexia was that she ambivalently sought proximity and care from her parents. However, when she had experiences in adulthood in which anorexia seemed to risk her attachment bond and the permanency of significant relationships (in this case, her partner), anorexia's effectiveness lessened and the utility of it started to diminish. Equally, Bethany talked about difficulties having her emotional needs met by her mother. She also described her repeated attempts throughout her life to find someone to "take care of her". From such an interpersonal context, anything that might threaten or jeopardise current attachment figures (her best friend), may make the maintenance of anorexia a high-risk strategy.

5.3(1) (e) Missing out on What I Want

Rosie had been advised by a professional in her care team that she would be unable to go to university because of the severity of her anorexia:

> "I'd also been told never to go to university by the Eating Disorders Service manager, she said, "You can't go, you wouldn't survive at university, you're not well enough, you need to spend a year here and work on your recovery". I was like, "Sod that, I'm going (Laughs). And I wanted to prove to her…"

She describes a form of retaliation against the Service manager's comments. Given Rosie's abusive background, it may have been important that she was able to make clear choices for herself, as well as reject judgements made by another. In her account about developing anorexia, Rosie described a variety of examples when she was criticised and judged negatively by others. She also gave examples of being controlled and influenced in an abusive way. I wonder if her ability to make choices and promote her own wishes was an expression of recovery. I then question if she was able to recover precisely because she had been able to cultivate a more nurturing intrapsychic relationship. Moreover, Rosie was a high-achiever academically and she began to question if she would be able to achieve at university whilst maintaining anorexia. In terms of the decisional balance (weighing up the advantages and disadvantages of maintaining anorexia), it appeared that Rosie began to perceive continued academic success and the possibility to enter university life as more important than maintaining anorexia:

> "And I think I was scared that I would fail. Academic stuff has always been, I've never failed anything and I was scared that I would come to university and if I had eating problems, I wouldn't pass my stuff, so it was that fear"

When describing causal factors in the development of her eating difficulties, Janice stated that the rivalry between her and her younger sister had been a contributing factor. When discussing extratherapeutic recovery factors, the sibling rivalry dynamic was present. An example of this was her sister's pregnancy and subsequent motherhood. Janice talked about feeling envious and wanting to have the same:

> "By this time, my sister had just had a baby and I was jealous and I wanted one too. Having thought that I never wanted to have a family, so some of it was totally unhealthy sibling rivalry, but some of it was that I discovered that I was, wanted to have a baby. Having told my husband that wasn't the sort of thing I would consider, I realised that was something I passionately wanted, to have a family. And I think I was willing to get better for that reason. So I tolerated very slow, reluctant

weight gain, and got pregnant and had my daughter"

In the same way that Ailsa's continued sensitivity to scrutiny from others contributed to her readiness to change, Janice's continued sibling rivalry also seems to have been important is supporting her recovery process. If having a baby (to have what her sister had) meant she needed to be physically stronger, and being physically stronger meant recovering from anorexia (or at least the physical and behavioural aspects of it), it seems that she was prepared to do this.

Having a baby was also important for Bethany. Her fear that anorexia may ultimately impair her fertility began to be experienced as more and more concerning. She suggested her partner would encourage an increase in her anxiety, calling this "The Baby Card":

> "Wanting kids myself is an incredibly important thing, erm. I would get scared that I wouldn't be able to have children, and D would call it 'The Baby Card' so when things got really bad and I basically wasn't trying at all, he would remind me how much I wanted children and knew that it would upset me, and it was horrible and really hurtful. Not cruel, just true".

It would be unreasonable to suggest that her desire to have children automatically links to her interpersonal history. This would require a belief that all women who want to have children do so because of developmental deficits. However, I wonder whether "The Baby Card" may be an expression of more than the desire to have a child and be a mother. It may also include her need to experience a "good enough" interpersonal bond, where she is securely connected in such a dyad, even as the caregiver and not the recipient of care.

5.3(1) (f) My Abuser and being abused

For Rosie, the relocation to university not only meant a change in daily routine, but also required her to distance herself from her employer who had been sexually exploiting her:

> "I thought, if I can get away from him, then I won't get better, Cos he was the one who was sustaining it after a while. Around my 18th

> birthday, I think when I got to 18, I knew I'm going to do it, and the only one who was constantly bringing me down was him".

Rosie suggested that her anorexia was being maintained by the sustained experience of sexual abuse. It was a significant point in her recovery when she was able to remove herself from this relationship. This made me question: Did leaving her abuser promote recovery, or was her action to relocate and distance herself from him a behavioural indication that recovery was already underway? It may have been a combination of the two.

Participants' accounts of recovery not only included their growing awareness of the disadvantages of maintaining anorexia, but articulated their hopes and aspirations of what life might be like without anorexia. A range of examples relating to the perceived advantages of Moving Towards recovery will be discussed next.

5.3(2) Moving Towards

Participants described a range of factors that contributed towards their perception of recovery as a positive, personally meaningful and egosyntonic endeavour. My interpretation of the data yields two related sub-themes. The first refers to recovery as a *Movement Towards* important and valuable interpersonal relationships. Participants talked about either new or long-term relationships and described both their valuing of the relationship and desire to preserve it. This is defined as the sub-theme 'Towards a Secure Base'. The second referred to recovery as a *Movement Towards* new opportunities, new life experiences and the possibility of new relationships. Participants gave a range of examples, from the possibility of moving to a new area to beginning a new course and establishing themselves within a new peer group. This is defined as the sub-theme 'Towards a New Identity'.

Firstly, participants offered important examples of the factors that motivated recovery. They included the centrality of relationships with husbands or partners (Janice, Emily, Ailsa and Bethany), having children or developing the wish to have children (Janice, Emily, Ailsa, Bethany) and the value of support from parents or significant others (Craig and Pamela). They also included the value establishing a new identity through the process of active decision-making, which in turn created the possibility of

influencing new life experiences. This included redefining identity with something other than victimhood (Leah and Anna), working through gender conflict (Janice) and resolving the developmental task of identity formation (Craig, Bethany, Kate, Nadia and Caitlin).

Secondly, I also heard descriptions of the ways in which participants described and discussed their recovery process or perhaps more accurately, how they have come to perceive that process now.

Thirdly, as was the case with the 'Moving Away From' sub-theme, positive factors that assisted participants with recovery are also inextricably linked to the factors that contributed to their developing anorexia. Moreover, I would argue that their accounts of recovery are not only causally connected to those of becoming ill; they represent a resolution of the underlying difficulties. In Chapter Four, superordinate themes of Attachment, Trauma and Identity were identified through data analysis. Moving on to analyse the data about recovery, these superordinate themes appeared to be present in participants' storied accounts of recovery. For me, participants' descriptions of recovery involved the working through of their Attachment, Trauma and Identity difficulties. I attempted to engage with the data as openly as possible, aware of the danger of searching for an association between participant's accounts of illness and recovery. Nonetheless, I concluded that recovery may be associated with a working through or resolution of the factors that triggered anorexia.

Whether is it ever possible to fully understand the causal factors in developing anorexia, the important issue participants' raise is their unique and personally meaningful perceptions and perspectives both on the development of and recovery from anorexia. Some even go so far as to postulate that the way they conceptualise what has happened will influence the trajectory of the eating disorder – for example, when Craig suggested that he needed to tell himself the illness was over, otherwise he was at risk of "a fall" (relapse).

Not only does the activity of narrating provide participants the opportunity to experience personal empowerment, but also provides hope that change is possible. Furthermore, the process of recovery is a dynamic, fluid and powerful mechanism for

change rather than a fixed, descriptive activity recounting and retelling how something happened in the past.

5.3(2) (a) Towards a Secure Base

A range of people and important relationships were identified by participants as positively contributing to their motivation to recover. Four participants highlighted the importance of their relationships with either their husband or partner.

5.3(2) (a)(1) Marriage/ Partnership

Janice described the importance of her relationship with her husband. She said that as someone with an appreciation of food, his influence, which included creating a lifestyle of eating together as a family, was 'anti anorexic':

> "My husband. He wouldn't collude also he's a bit of a gourmet. He likes food and has a lot of French blood in him and he really loves it when we all eat together. And we do try to eat together as a family".

During her earlier descriptions of food and eating within her family of origin, she described eating as a functional activity, eating "an egg to keep the wolves from the door". This is a stark contract to her description of her husband's love of food and the way in which eating provided a framework to spend time together as a family. From a recovery perspective, it is possible that Janice's later experiences with her husband and children offered reparative experiences where food and eating is social and pleasurable.

Emily discussed the importance of her marriage and specifically talked about the importance of moving to Scotland and buying a house with her husband:

> "It was partly moving here, I moved here when I was about 28, um, and I think for the first time I felt really - I was married by then, um, but we'd bought this house, and I felt really rooted here somehow, I mean I just loved being here, and it was like this was what I wanted, this was my dream, you know, and I had it, and I had a husband and I had this house that I really liked and a home, and I think I felt that I could be me. This is what I wanted".

Linking this extract to descriptions of her experiences with her mother, I am struck by the differences in the way she narrated her childhood and adult relationships. In contrast to her mother, whom she described as "emotionally abusive", her relationship with her husband is described as respectful and kind. She also associated married life with other important things, such as having children, living in a "home" and belonging to a community that she felt "rooted" to. The absence of nurturing relationships when unwell and the presence of more supportive interpersonal relationships when recovered suggest that there is a contribution of interpersonal influences both on developing illness and recovery.

Ailsa also discussed the importance of meeting her husband in supporting her recovery. She used an evocative metaphor of being a "square peg in a round hole" before she met him. She then referred to a sense that she "fitted" after meeting him:

> "I always felt like a square peg trying to get into a round hole. I never felt like I fitted, at university, a very sociable person, but never felt like I fitted. Now, when my kids came along, and B came along and life is never simple, but I started to fit. I started to think 'I fit here, this is just (pause) comfy'. And I've only ever had that 'comfyness' with B".

Earlier in this chapter, I referred to Ailsa's self-scrutiny and her perfectionistic traits influenced by what I see is her anxious attachment style. Therefore, her use of the word "fit" is potentially an expression of the developmentally-needed experience of a secure interpersonal attachment.

Bethany talked about her relationship with her partner and the challenges anorexia placed upon him personally and them as a couple:

> "He wasn't ever particularly good at understanding why, he learned to accept that, and not try to understand why something was happening, but just that it was. And that it was an issue for me. And he put up with crap. A lot of it actually because there was so many things that he couldn't do, because I couldn't do them, like we couldn't go out for meals and when we tried we'd have to deal with me freaking out and running out. And, he'd have to deal with the embarrassment and he just kind of did it. Not saintly or anything, he did get angry with me, he got frustrated, he got upset, he got (pause) absolutely to the end of his tether. But he was always there and he, that I think helped so much"

I think she may be expressing the capacity for their relational bond to withstand the stressors that anorexia placed upon their relationship. This can be contrasted with her description of the fragility of her emotional bond with her mother and the sense that her mother was unable to attend to Bethany's emotional needs.

While each participants account is unique, they also appear to have something pulling and linking them together. Each of the participants used a range of different descriptions and examples to describe the experience of a secure interpersonal relationship, one where their significant other has an influence on them and how they live, affects how they view themselves, and perhaps offers the reparative opportunity to experience the secure bond that was absent in their early relationships. For Janice who perceived that she was unwanted and the "wrong sex", to have a husband whom she believed loves and accepted her for who she is (including her womanhood) is potentially transformative. For Emily, who felt "suppressed" by her mother's judgements and the projections of her mother's unhappy marriage, to begin to think about herself as someone who could decide where and with whom she lived is equally powerful. For Ailsa, who worried about her parent's marriage, witnessed events that led to her interpretation of her family as insecure and resulted in her engaging in 'perfect child' compensatory behaviours, the meanings of "fitting" with someone and having "comfyness" may link to the experience of feeling accepted, valued and secure. Finally, for Bethany who described her perception that her mother was not emotionally available to her and that, as a child Bethany adopted a care-giving role, the experience of a relationship where the significant other was consistent and remained so through a significant period of testing was also potentially healing.

5.3(2) (a) (2) Children

Emily, Janice and Bethany also mentioned the importance of children in influencing their motivation to recover. This is associated with the wish to have children, or the desire to have the relational capability to nurture a child (either as a parent or older sibling). Less obviously, I think these descriptions are also about the ways in which care-giving requires the caregiver to be sufficiently self-caring and protective.

Emily connected her developing awareness of the wish to have a child as a further signpost of her own recovery:

> "I think because I felt kind of grounded and settled, and I was at that age when I started wanting to have children, and um, and I started to sort of think, well, that, and I knew in myself that that was me recovering, kind of recovered if you like, because I hadn't wanted children before then, but once I knew myself that my attitude had changed completely, and my life had changed, um, and I suppose it was just part of kind of, being able to express myself and be myself and I knew that I'd sort of come through that".

Emily mentioned attitudinal changes as well as practical changes in her life. Emily reached a stage where she felt emotionally ready to meet the needs of another and be part of an attachment pairing where she was the primary caregiver. She articulated the consequences of having found, and being provided with a secure interpersonal base. As she described it, being "grounded and settled".

Bethany referred to her relationship with her younger sibling and the desire to be a "positive role model":

> "My little sister being born was quite (pause) it was important because I've been well almost as long as she's been alive, erm, but then I really didn't want to (pause) for her to pick anything up from me when she was already in the same family that I was in. I wanted to be another positive role model, somebody who could be comfortable with who I was".

It appears that both her wish and capacity to be a positive role model for another is indicative of developmental progress; to have received "good enough" care experiences to be able to provide for another. This is similar to her description of "The Baby Card", with Bethany expressing the wish to be a caregiver. What is different is her awareness of the need to be sufficiently robust herself in order to offer care and protection to another. Indeed, these extracts about children touch upon the ways in which the caregiver role requires particular capabilities from the caregiver. These accounts allude to interdependent processes, in which caregiving is also an indirect way of ensuring that they adopt a more compassionate and nurturing relationship with themselves. So, *in order to care for the other, I need to care for myself*.

This is precisely what Janice mentioned in her discussion of motherhood:

> "Motherhood, but in two parts. Because with both children, it's been very very important to give them enough self-esteem, assertiveness and self-care. To do that, I've had to be sufficiently balanced and feed myself and cook for them".

Janice clearly stated that in order to adequately care for her children, she needs to adequately care for herself. Considered in relation to her description of early interpersonal experiences, Janice did not perceive that she had sufficient self-esteem to promote self-care. In having and looking after children, she hoped to provide them with the core interpersonal and intrapsychic aspects that were deficient in her own childhood. Moreover, in providing these aspects for them, it is necessary that she somehow found a way to provide these aspects for herself. I think this is the meaning of being "sufficiently balance".

5.2(2) (a) (3) Parents

Craig described the importance of his relationship with his parents as contributing towards his motivation to recover:

> "You know my mum and dad are really behind me, really supportive, you know if it wasn't for them I wouldn't be where I am, you know they really, really supported me they did well, that does make you, you know?"

In terms of the onset of his eating disorder during adolescence and the challenges of negotiating relationships with peers, the relationship with his parents appeared to have been highly significant. He described being offered nurturing and caring experiences during his illness. When Craig said, "If it wasn't for them, I wouldn't be where I am now", I understand this as an internalisation of their care and support, which, in turn, helped him to develop optimism about his future.

Craig's account of his relationship with his parents is very positive and they are cast as helpers in his recovery. This is in contrast to many of the other narratives where parents appear implicated in the cause of the illness. Although Craig's parents were unable to prevent his illness, they were not associated with his illness developing.

His account is more closely connected to the position that families are not part of the problem. However, for the majority of participants in this study, families, in a variety of ways and for a range of reasons, are implicated as 'part of the problem'.

5.3(2) (a) (4) Significant Others

Both Bethany and Pamela mentioned the role of other significant people in helping motivate them towards recovery. For Bethany, this was talking to a woman who had previously suffered from an eating disorder. Bethany established this contact through the Eating Disorders Association (now known as b-EAT):

> "And then I spoke to M, she ran the support group, and she was my EDA contact. And I phoned her up and spent 2 hours on the phone to her the first time I spoke to her, and she was the first person I'd ever spoken to who had actually had an eating disorder. The first person that I could say, "I feel like this" and she could say she understood and I remember that feeling of absolute revelation just having that reflection from somebody".

Unlike support from her family, friends and partner, she described a particular type of interpersonal exchange, centred on the perception of being truly understood, what Bethany referred to as "that reflection". This extract is significant from a recovery perspective as it points to the possibility that Bethany was able to find ways to access developmentally needed interpersonal experiences, from a range of sources.

For Pamela, the significant other was the person she referred to as the 'in-between guy', the employee of the family who transported her between her mother and father after they divorced. Within her narrative, she powerfully described her belief of being misunderstood by her family, that she was alone with her difficulties:

> "And nobody could understand, everybody was talking about it in my family; no-one could recollect what was going on. I didn't feel safe, I just wasn't feeling anymore. And he'd always said to me all the time, 'Don't worry darling. You will get over this. You're quite clever.' And I think that had really, really helped me, you know, that positive thinking".

When I first read this extract, I immediately recalled Pamela's words, when she stated, "My father never gave a fuck about me". I also thought about her saying that her mother was "in denial" about her eating disorder. Within the same account, she

then introduced this man, who said kind, gentle and supportive things to her. I consider him to be a significant other both because she specifically says that his "positive thinking" helped her, and also because she mentioned his death as a precipitant to a relapse of her eating disorder in her mid-twenties.

This reminds me of the concept of resilience, which includes the capacity to find nurturing experience wherever they can be found. Gordon (1995) argued that if a child is to thrive, mature and increase competence, they must "draw upon all of his or her resources: biological, psychological and environmental" (page 242). Pamela's extract is an example of this.

5.3(2) (b) Towards a New Identity

Participants described the importance of developing new relationships and having new opportunities and experiences open up to them for recovery. Within each of these transitions to new 'people or places', participants were able to begin establishing and redefining their own sense of identity. Therefore, these accounts are not merely rehearsals of what they did and with whom, but communicate how they came to perceive themselves, others and their world in relation to their life history. This sub-theme relates to personal identity and is expressed and discussed in a number of ways. Accordingly, I have organised the data under the headings: Who I Am and Who I'm Not; Being a Woman and Being a Survivor.

5.3(2) (b)(1) Who I Am and Who I'm Not

The following extracts from Craig, Bethany, Nadia, Kate and Caitlin all refer to being able to try something new in life and pursue a range of activities and interests. Not only are these activities and interests useful in the sense of providing a meaningful structure to their lives, they also demonstrate participants' efforts to clarify the roles they wish to take up and occupy and in doing so establish a sense of identity, an idea of Who I Am.

Craig discussed the importance of being aware of and known for his talent as a footballer:

> "In the last couple of years you know I have developed a really, I don't know a quite good talent for football, And eh, so like 3 times a week I'm playing football, with different boys every time, because you know? It does you know help you with stuff like that, I think when I was younger I was quite low in confidence didn't believe in myself, but now you know I do. Don't have the same fears or anything like that".

Craig compares his self-esteem from past to present. In his account of developing anorexia, he was bullied for his weight, shape and facial acne. He described this as a "tender age". In his account of recovery, he mentioned the importance of being a footballer, of interacting with a number of different football teams and being in a position where he can negotiate such peer activities. From an Identity perspective, Craig appears to be articulating how he had changed the way he sees himself. Now, he is a young, talented, popular footballer, not, the "chubby", "spotty" teenager.

Bethany described the importance of her linguistics course at university:

> "And University, Linguistics (pause) that was hugely (pause) that was a thing that kept me going because that's where I was aiming for".

I think about her course as a significant anchor in establishing a coherent sense of identity. From an Identity perspective, she is articulating that she is an able, competent student, doing what many other people of her age are doing, not a person impaired significantly by illness.

Kate talked about the importance of training to be a nurse:

> "Nursing yeah. And when I started University as well, like because I got into, I got into a new group of friends who didn't have any idea what had happened in the past. Erm, and I went to the whole Freshers' week thing and like I put, I probably put (laugh) I put on the most weight in a week that I've ever put on just because I felt so comfortable being around people who didn't know my history and they didn't expect me to have a problem with food, so I didn't have to conform to having a problem with food. Erm, and it was just really, it was just really nice to get out of the school environment where everybody had known that I had left school because anorexia: all the teachers knew. And although it was nice that everybody was looking out for me when I was at school I felt like all I was, was an anorexic when I was at school".

Not only is Kate describing the importance of starting university and training to be a nurse, she is also commenting on the relationship between context and identity. She suggested that friends and teachers at school had become so accustomed to her identity as "anorexic", that she found it difficult to be anything different. Typecast, she may have felt pressure to conform to this role. However, when she moved to a new environment, the people at university had no preconceptions about her identity. In this new context, she was liberated to leave her illness identity behind and experiment with new and different ways of being.

Caitlin discussed her studies in occupational therapy:

> "I reapplied to University to do O.T and I found who I was and I looked at all the friends I'd made who liked me for being me and not being what everybody wanted me to be, not for being someone who was going to go to Uni and be a doctor and blah blah blah. They liked me just for being C (name of participant), the bum who didn't do anything, whose life was a mess! And they still liked me. So it kind of helped".

Caitlin is expressing a number of important issues in this extract. Firstly, she identified the importance of studying occupational therapy, rather than medicine. In her account of developing anorexia, she expressed her concern that she was "not being heard" and felt her parents had high expectations of her academically. Therefore, when she talked about commencing a university course of her own choice, Caitlin was deciding for herself who she wants to be - in this case, an occupational therapist (and a bum!), not a doctor, burdened by the influence of parental expectations. In addition, the experience of being "liked" after making independent choices may also be a developmentally needed experience of unconditional acceptance (in this case, from friends). This helped to mitigate against earlier experiences of conditional striving.

Nadia also described the importance of commencing her university degree in nursing:

> "I think I just realised that I didn't want to carry on like that, there was an opportunity that I could come here and I could do nursing and I could meet new people, I wanted to do stuff like that".

Recalling her earlier description of being sexually abused prior to the onset of her eating difficulties, I began thinking that the meaning of establishing a role as a student and eventually as a nurse. In choosing to define herself by these measures, she is moving beyond being a victim of abuse. She is redefining herself as a Survivor.

I wish to comment on a number of common issues in the Who I Am and Who I Am Not extracts. Firstly, each of these participants was in his or her late teens/early twenties and involved in the developmental processes of leaving home, beginning to engage in study or work and finding significant relationship outside the family. A central aspect of this developmental phase relates to identity formation and I interpret these extracts as relating to a natural developmental pull towards independence. Secondly, these accounts of recovery also relate to developing anorexia. Each of these young people expressed challenges with their developing identity and placed them alongside their story of developing an eating disorder. As explored previously, Craig talked about bullying and wanting to be accepted by his peers. Bethany described the sense that she did not fit in either at school or within her local area. Kate talked about her pervasive sense of being trapped within her identity of anorexia, one she felt she needed to comply with because of the expectations of others. Caitlin described frustrations associated with parental pressure to achieve academically and study medicine. Nadia mentioned the role of being sexually abused and her difficulties attending school and being able to sustain activities of daily living. Therefore each of these descriptions of what they were *Moving Towards*, as part of their recovery incorporate an emerging awareness of their own self-identity.

5.3(2) (b) (2) Being a Woman

For Janice, an important aspect of her account of developing anorexia related to her perception of being unwanted, that her birth had negatively affected the life course of her parents and that she had been a disappointment as her parents had wished for a son. In the following extract, she describes having her own children, and how the process of motherhood has enabled her to value her gender:

> "Once I discovered that motherhood was a worthwhile thing and was prepared to be a woman, wanted to do that, I started living as a woman. So, it's almost like I started to live like a boy right up until my 30's, and

> then I discovered being a woman was absolutely wonderful. And I've been a woman ever since. It's almost sex change my recovery".

To describe recovery as a sex change is a powerful analogy. Janice is articulating a "disowning" of her femininity through anorexia and a "reclaiming" of it during recovery. To alter from female to male and back again is a significant shift in self-identity. Much has been written in the feminist literature about women's oppression through the body. Greenspan suggested, "A woman in contemporary patriarchal society is fundamentally identified with her body. Men are their brains; women are their bodies. Man is culture. Women is nature. Woman is Woman as Body" (Greenspan, 1983, page 164, cited in Brown and Jasper, 1993, page 361). This idea is helpful in considering Janice's identity struggle as it reflects the somewhat ambivalent position she held about men and women and their respective roles. Janice wanted to be a boy to be accepted by her father, to be a young man at university to protect herself from the "sexual onslaught" of male attention and to continue as a man to secure her place as surgeon (a male dominated branch of medicine). Therefore, when she articulated the desire to be a mother, it seems this is an expression of a willingness to allow herself to be a woman or embrace the feminine aspects of herself.

5.3(2) (b) (3) Being a Survivor

Leah perceived the onset of her eating disorder as inextricably linked with the sexual abuse she suffered as a child. In the following extract, she talks about a telephone call with her father. During this conversation he disclosed that intergenerational abuse had taken place within their family. He further disclosed that he was a victim of sexual abuse in his childhood:

> "He went "Look see (pause) I need to apologise. For everything that I've done to you". And I'm like, "I can't believe you just said that". But I was sobbing. I was completely sobbing because he has never even attempted to speak. He's never came right out and said what it is. He says, "That's the Thing that happened to me when I was a wee one". You see, I've never knew any explanation for this. He says "And I've carried it on into my family". He says, "And I'm so glad that you've not (pause) you've stopped it. That it's not carried on into yours". I says, "Well that's fine because I'm drawing a line right under everything. Now please don't phone me again. I mean, I can't keep in a stable frame of mind when you want to phone me and you want to be in my life because

I don't want you there. So please don't phone me again".

This extract contains a number of important recovery-focused issues. Firstly, her father offered an explanation for his actions. Secondly, he offered an apology. Although this would not be able to 'undo' the betrayal that had occurred, his apology is an admission that he did something he should not have. At the very least, this validates her suffering. Leah then described her intention to "draw a line under it". This is another powerful metaphor that evokes the idea of creating a visual separation from past abuse. If Leah is able to separate herself from it in time and space, she may be able to stop defining herself solely in relation to it - in other words, challenging her status as a victim and offering the opportunity for a new identity as a Survivor. The former identity would define her in relation to her abuser and her powerlessness, whereas the latter would seek to define her in relation to her resilience and capacity to live beyond it.

5.4 Conclusions on Recovery from anorexia

Within this chapter, I have reviewed participants' personal accounts of recovery from anorexia. This has included their beliefs about what recovery is and the factors that supported them in making a recovery. I will revisit each of these in turn.

In Chapter Two, I reviewed a range of literature on recovery from anorexia and highlighted the significant difficulties with conceptualisations and measurements of recovery (see *2.5*). Interestingly, findings from this study also indicate differences in how participants define and measure their own recovery process, although I believe these differences stem from other concerns.

In the academic literature, some of the conceptual challenges relate to the criteria used to measure recovery with authors and researchers placing different emphases on physical, behavioural and/or psychological indices. Within this study, the EDE helped to identify that all participants had reached a particular level of physical and emotional health. This includes attaining a healthy body weight (see Appendix 5) and engaging in minimal anorexia supporting behaviours, such as dietary restriction or compensatory

actions after eating. However, participants scores for weight and shape concerns highlight that difficult thoughts and feelings associated with weight, shape and eating persist, albeit that their scores on the EDE were outside of the norms for people with anorexia and bulimia.

It is intriguing that even when employing the highest conceptual threshold of recovery, all participants in this study would be deemed to have recovered. Yet some of them consider that it is not possible to reach a point of complete recovery. Indeed, while some participants perceive recovery as an actual state, which can be reached and then maintained, others perceive it as a new way of managing the challenges that anorexia creates.

While this might relate to more fundamental problems with diagnostic classification systems and the limitations these place on human experience, having attended to participants' accounts of developing anorexia, I understand each participant's perception of recovery as a 'Journey' or 'Destination' in relation to their stories of becoming unwell. Experiential accounts of recovery are heavily saturated by a working through of the issues most vivid and important in developing anorexia.

Moreover, I believe it is significant that the majority of participants who experienced more aversive life experiences, higher levels of trauma and more problematic interpersonal histories prior to developing anorexia, view recovery as an on-going process. In other words, I conclude that the enduring nature of anorexia for some may be an expression of the lasting effects of other types of distressing and damaging human experience. However, there is also much to be said about the role of psychotherapy in assisting with some of these significant life issues and this will be further explored in Chapter Six.

Moving onto factors that support recovery, participants narrate this in two main ways. Firstly, I conclude that recovery can involve a process of *moving towards*, reaching and attaining a range of life goals. Secondly, I conclude that recovery can be motivated by the desire to *leave behind* the negative consequences of anorexia.

A discussion of the findings in relation to other qualitative studies that explore subjective understandings of recovery from anorexia will be discussed in Chapter Seven.

Much of this chapter has focused on the factors outside of treatment that have supported recovery, although participants all suggest that their experience of psychotherapy aided their recovery process to a greater or lesser extent. As previously mentioned it is problematic to consider such factors completely separately as therapeutic and extratherapeutic factors interact and influence each other. They are not as independent as their delineation in the chapters of this thesis might imply. This will be reviewed in the next chapter, which will explore the role of psychotherapy in recovery from anorexia.

6 The role of psychotherapy in recovery from anorexia

6.1 Introduction

In Chapter Five, I explored a variety of extratherapeutic factors that participants identified as important in their recovery. In this chapter, I intend to explore the role of psychotherapy and in doing so to elucidate participants' accounts of the therapeutic factors that contributed towards their overall recovery process.

Participants were asked to explore the role of psychotherapy in their recovery from anorexia. Participants were asked if psychotherapy aided their recovery and invited to explain how they believe it worked, what was most helpful, what made the biggest difference and whether there are aspects of therapy the participant continues to use to sustain his or her recovery. Following interview transcription and data analysis, 87 principal sentences were filed in NVIVO, which describe the role of psychotherapy in participant's recovery process.

When exploring the role of psychotherapy in recovery, I started to interpret participants' experiential claims by looking for common factors across their therapy experiences. I did this because my review of available literature identified that sufferers can be offered a broad range of psychotherapies and it would be helpful to better understand if there are particular models of psychotherapy that the recipients of them find more or less helpful and gather more detailed information about what occurs within therapy.

However, participants were offering significant connections between their experiences of developing anorexia and their subsequent experiences of psychotherapy, what had been helpful and why. As a result, I also examined participant's experiential claims in relation the provision of specific types of therapeutic relationships, namely the experience of the working alliance and developmentally needed/reparative relationship (see Clarkson, 1990). Therefore, within this chapter I intend to illustrate both common factors and therapeutic relationship approaches. To do this, I will:

1. Offer examples of common factors across therapeutic approaches from the data set;
2. Offer an example of data analysis using both the common factors and therapeutic relationship approaches to illuminate different types of meanings that are constructed; and
3. Offer examples of therapeutic relationship approaches across the data set with specific reference to participants' accounts of developing anorexia.

6.1(1) Common Factors across psychotherapeutic approaches

The common factors found in the range of therapeutic modalities participants' received can be broadly grouped under the three domains of support, learning and action factors (Grencavage and Norcross, 1990). Support factors are defined as the necessary and, arguably, sufficient conditions (for example, see Rogers, 1967), which facilitate change for the recipient of psychotherapy. These factors relate to the non-technical aspects of therapy and rely heavily upon the quality of the therapeutic relationship, characterised by accurate empathy, positive regard, non-possessive warmth and congruence or genuineness. Grencavage and Norcross identified 12 support factors. Learning factors relate to the opportunities provided in therapy to acquire greater insight and understanding into current difficulties as well as new skills to manage cognitive, affective, behavioural and physiological stimuli. Grevcavage and Norcross identified 10 learning factors. Action factors are located within the behavioural domain and relate to the application of learning and support factors - in other word, how the recipient of therapy is able to act and interact within their social context. Grencavage and Norcross identified 8 action factors.

Table 10 below lists support, learning, and action factors associated with a positive outcome. These were used to organise and review common factors. I also provide an example of each type of common factor drawing upon extracts from the data set.

Table 10: Sequential List of Factors associated with Positive Outcomes in Therapy

SupportFactors	**LearningFactors**	**ActionFactors**
Catharsis You know you got it off your mind, you got to talk about it if you know what I mean, it wouldn't be kept inside you, you know, you'd think about it all the time, you'd get it out and talk about it. It would feel much better. *Craig*	*Advice* My therapist was the one who really suggested I needed to start gaining weight. She said that until I was nourishing my body and mind, I really couldn't begin to make a recovery. She advised me to see the dietician to get a meal plan sorted, so I did that. *Kate*	*Behavioural regulation* It wasn't till I met T (therapist) that things changed. And he done a plan with things, like about how I was eating and when I was eating. I started off with what was a wee brown cup that was like a (pause) espresso cup? And built up from there. *Leah*
Identification with therapist It took a long time, but eventually I moved from the side of destruction, to the side of life. I wanted to be living on the same side as her. *Rosie*	*Affective experiencing* I was spending a lot of time thinking about the past which I'd kind of put behind, well I'd thought I'd put it behind me, um, and obviously it was very painful stuff that was um, stuff I didn't really want to kind of remember but um, but once you sort of thought about it, it brought back all sorts of other memories and um, I kind of realised, I didn't kind of consciously realise I was going to have to go through it all like that. *Emily*	*Cognitive mastery* Like I do catch myself thinking things like (pause) negative thinking (pause) and I do kind of pull myself up on it. Erm (pause) what has stayed with me (pause) erm (pause) I think now whenever I get one of my core beliefs coming through, I identify it for what it is. And because I have that CBT engrained in me now, and I'm sitting there feeling like I'm not that good, you've been trained a million times to just let it go. *Caitlin*

Positive relationship I honestly quite enjoyed you know coming in and talking away you know I would quite enjoy it, I think it did help me, it gave me just what I needed I felt you know, it just really made me feel respected like. *Craig*	*Changing expectations for personal effectiveness* It wasn't until I met T that I gained the control thing; it was because he had control over me. Dad dictating what was happening in my life. How my life was turning out. And it was T that taught me how to get rid of that so that might not be a burden on me anymore. *Leah*	*Modelling* Once I got to know her, I started to look up to her and what she was doing. I used to think, "C can eat, so why can't I". I used to think about that a lot; I think I wanted to be like her. *Kate*
Structure The session was directed by (pause) me. V kind of did the horrible thing where she would sit and look at me until I spoke. She didn't really (pause) I liked V (name of professional); I liked having structure so it was (pause) yeah I liked it when it was led by what I wanted talk about. *Rosie*	*Exploration of internal frame of reference* Yeah I think it helps you realise what it was like I wouldn't have thought it was definitely that I wanted to take back control. Looking at it through the CBT eyes, you kind of reflect on things. *Caitlin*	*Modelling* Once I got to know her, I started to look up to her and what she was doing. I used to think, "She can eat, so why can't I". I used to think about that a lot; I think I wanted to be like her. *Kate*

Therapist-client active participation He promised me that none of the stuff we talked about what go to anybody else and I could use it how I wanted so (pause) that was important. *Leah*	*Insight* It helped me understand things, I think, better, you know, the things I hadn't understood and once you actually start to talk about it, you can sort of, certainly with a longish sort of hindsight you can sort of like, um, actually understand why, and say well, and things have changed so I don't need to be like that anymore, I can move forward. *Emily*	
Trust I could tell her anything and I knew she would help me as best she could. I just knew she was on my side that helped so much. *Nadia*		
Therapist warmth, respect, empathy, acceptance, genuineness You know, just having someone to talk to, just the, the warmth, that was a huge thing. *Bethany*		

From: Handbook of Psychotherapy Integration (Norcross and Goldfried Ed, 1992, page 105)

This table illustrates that regardless of the therapeutic orientation of the psychotherapist, participants' experienced a range of support, learning and action factors within individual psychotherapy. Four participants said they had been offered cognitive

behavioural therapy. The remaining participants said they were unsure of the actual model of therapy that was being offered, but were able to describe what actually took place within their sessions. With these participants, it is difficult to infer the precise model of psychological therapy offered but is possible to identify the types of psychotherapeutic interventions that were used based on participants' descriptions of what occurs within psychotherapy.

I heard descriptions of a range of eclectic interventions, based on assessment and therapeutic goal-setting. This included solution-focused interventions, such as creating personal safety from abusive relationships, and/or strategies to assist with regulating eating patterns and weight restoration as well as support and guidance to make important transitions, such as leaving home, moving to a new area and/or starting an educational course. I listened to accounts of trauma-focused work, and interventions aimed at teaching psychological skills in interpersonal effectiveness, distress tolerance, emotion regulation and improving meta-cognitive awareness. I will discuss these therapeutic interventions further in this chapter.

However, without exception, all participants discussed the centrality of the therapeutic relationship with their therapist. Initially, I recorded this data as further evidence of a support factor. However, the repeated emergence of this issue influenced my decision to begin examining the therapeutic relationship in more detail as an additional aspect of data analysis.

6.1(2) Shifting from (Common) Therapeutic Factors to Therapeutic Relationships

As mentioned, I found it increasingly problematic to separate participants' accounts of psychotherapy from their broader stories about becoming ill and their eventual recovery. In other words, it seemed to be unhelpful to try to separate the part from the whole. This, coupled with participants' descriptions of the centrality of the therapeutic relationship resulted in a move from common factors onto participants' experience of the provision of specific types of therapeutic relationships, namely the experience of what Clarkson described as the working alliance and developmentally needed/reparative relationship (Clarkson, 1990).

I shall begin by explaining these relationships further. Next, by drawing upon an example of an apparent support factor, I argue that a deeper and more significant understanding is offered when drawing upon Clarkson's relational model. This links to Heidegger's notion that interpretation is influenced by the preconceptions brought to the interpretative process. As Smith et al (2009) suggested, "One can hold a number of conceptions and these are compared, contrasted and modified as part of the sense-making process" (page 26).

6.1(2) (a) Types of Therapeutic Relationships: The Working Alliance and the Developmentally Needed/Reparative Relationship

Clarkson created an integrative psychotherapeutic framework containing five possible modalities of client/patient-psychotherapist relationship (Clarkson, 1990). This framework is based on an integrative principle that focuses on similarities and differences between different psychotherapy approaches and differentiates which relationships each approach tends to favour or draw upon most frequently. These include the working alliance, the transferential/countertransferential relationship, the developmentally needed/reparative relationship, the person-to-person or real relationship and the transpersonal relationship. Clarkson (1995) suggested that some psychotherapies claim that "psychotherapy requires use of only one kind of relationship, or at most two: the working alliance and the transferential relationship" (page 5). For participants in this study, I believe there are two dominant therapeutic relationship modalities in operation. These are the working alliance and the developmentally needed/ reparative relationship.

Clarkson (1995) defined the working alliance as:

> the part of the client-psychotherapist relationship that enables the client and therapist to work together even when the patient or client experiences some desires to the contrary (page 31).

The working alliance relates to the cooperation between the client/patient and therapist that underpins effective helping. Bordin (1979) divided the working alliance into three main parts, involving goals, tasks and bonds. Goals relate to the agreed goal or desired outcome of therapy. Tasks relate to the interventions required to

achieve those goals. Finally, bonds relate to the quality of the relationship between client/patient and therapist, the emotional and personal connection that will facilitate the work, even when it is difficult and either or both parties wish to avoid it.

Clarkson defined the developmentally needed/reparative relationship as the:

> Intentional provision by the psychotherapist of a corrective, reparative or replenishing relationship or action where the original parenting was deficient, abusive or over-protective (page 108).

For the therapist to be able to respond appropriately to these needs, Clarkson suggested this requires "nurturance and development of the capacity to identify the nature of the injury or the kind of developmental deficit" (page 199). She argued that for some clients/patients, difficulties relate to a developmental period, rather than a one-off event. Such difficulties can lead to developmental 'arrest', a situation in which the individual is unable to grow and move progressively through later developmental stages towards maturity. Clarkson highlighted the role of '*strain*', "the subclinical experience of pain, rejection, deprivation, neglect, pressure, coercion, or seduction" (page 121), which can lead to accumulative trauma and ultimately impair developmental processes. In addition, she discussed specific traumas. These include incidents or occurrences where pain and suffering is intentionally inflicted upon an individual, as well as *'extra-familial limitations and catastrophes'*: "the damage visited upon children or adults through accidents of genetics or nationality" (1990, page 121). In summary, the developmentally needed/reparative relationship can attend to discrete incidents of trauma as well as developmentally limiting experiences sustained over a period of time.

6.1(2) (b) Narratives of psychotherapy and the Common Factors approach

In Table 10, I illustrate examples of the application of the common factors approach to participants' accounts of the role of psychotherapy in recovery. However, I was aware that in their descriptions and discussions of how psychological therapy aids recovery, participants repeatedly referred to the quality of the therapeutic relationship with their therapist. This 'support factor' was evidenced significantly more than any

other. On that basis, I decided this issue merited further investigation within the data analysis process. This resulted in a shift in data analysis, involving a movement between the common factors *and* therapeutic relationship approaches, before finally moving into an analysis of accounts of the role of psychotherapy from a more detailed therapeutic relationship perspective. To illuminate the process of moving between common factors and therapeutic relationship approaches, I will discuss an example of an apparent support factor next.

6.1(2) (c) Reviewing a Support factor

Janice described a particular incident when her therapist offered to make herself available outside of their therapy time:

> "There was one particular moment. When I was seeing (therapist), when it became absolutely personal (pause) because I was still having seizures and (husband) was getting totally fed up getting called to come and rescue me from Casualty. Then he was horrible to me and it was just dreadful! And she said, 'You know what you could do, you could just have a card with my name on it instead?' And I was just so totally taken aback and thought she must have misunderstood. And I was sort of saying, 'Well, they wouldn't be able to get you' and she said 'Why wouldn't they?' When I found out she was actually offering, not even just in working hours, to actually rescue me from Casualty, I thought 'My goodness, this woman actually cares about me and it's not just because she's paid to do it'. And I realised at that point that she must actually like me, and I've never felt wanted".

Analysing this extract using the common factors approach, I initially record this as a support factor and specifically an example of *Mitigation of isolation*, a *Positive relationship* as well as *Therapist warmth, respect, empathy, acceptance, and genuineness*. By offering her contact details to be added to the crisis card, her therapist was offering to be available whenever needed. Janice would no longer need to manage such incidents alone or risk further strain on her relationship with her husband. This intervention is clearly perceived to be supportive.

However, shifting analysis to the therapeutic relationships approach, the provision of a developmentally needed/reparative relationship allows for, in my opinion, a more profound understanding of what was being offered therapeutically. Within the extract, Janice suggested the following key perceptions: (a) her therapist genuinely

cares about her; (b) her therapist likes her as a person and (c) she had never felt wanted within her family of origin. This statement is inextricably linked to Janice's earlier description of her relationship with her parents, being born "accidentally", effecting her mother's life course, and being born the "wrong sex". From an attachment theory perspective, psychotherapy can be conceptualised as the creation of a secure base (Byng-Hall, 1995), in the same way that early relationships offer a secure base for the developing child. Within this therapeutic transaction, Janice's therapist was not eliminating her interpersonal history, but was potentially providing new experiences that could be incorporated into her internal working model, updating the model with validating and supportive relational information.

This example illustrates that findings derived from qualitative research are contingent upon and significantly influenced by the selected method of data analysis. However, the flexibility of the inductive/deductive process allows for examination of the 'fit' between source data and the analysis method, supporting the identification and exploration of significant themes. Indeed, the additional round of data analysis from a therapeutic relationship perspective adds additional insights from the data.

Schleiermacher (1998) believed that if one engages in a detailed, comprehensive and holistic analysis, the researcher can reach a deeper understanding, or, as he puts it "an understanding of the utterer better than he understands himself" (page 266) - for example, as highlighted for Janice, by reflecting on *why* she may have found particular aspects of psychological therapy useful based on her experiential account of developing anorexia.

I decided to explore the hypothesis further, namely that psychotherapy may be perceived to be most useful when it addresses the important issues surrounding sufferers' personal understandings and meanings of developing anorexia. I did this by reformulating participants' accounts of the role of psychotherapy in recovery into examples of the provision of a developmentally needed/reparative therapeutic relationship.

6. 2 The therapeutic relationship: centrality and components

Given my contention that participants' accounts of recovery are inextricably linked to their subjective understandings of casual factors in developing anorexia, I was intrigued to explore if the issues participants perceive to be important in developing anorexia were addressed within their accounts of psychological therapy.

I wished to examine and illuminate the ways in which psychological therapy may (or may not) address personal beliefs surrounding predisposing, precipitating and/or perpetuating factors. My examination of predisposing, precipitating and perpetuating factors within accounts of developing anorexia led to the identification of the superordinate themes of Attachment, Trauma and Identity. Accordingly, I interpreted participants accounts on the role of psychotherapy from the thematic perspectives of Attachment, Trauma and Identity.

One of the most striking features in reviewing participants' accounts of the role of psychotherapy in their recovery is the quality of the emotional bond between the participant and their psychotherapist. When listening to their descriptions of therapy and their psychotherapists, they described a person or a relationship possessing all of the characteristics one might expect in any form of nurturing, supportive relationship, whether that of a family member, friend, lover or spouse. They used statements like "good care", "having someone to talk to", "being treated like a normal human being", "being given permission". They said that psychological therapy was "personal" and "reassuring". I believe many types of relationship are 'therapeutic', in the sense that they are healing, have a good effect on the body and mind and contribute to a sense of wellbeing. These are not exclusive qualities within formal therapeutic relationships. Indeed, it is the development of a strong, supportive, yet fundamentally *ordinary* relationship that allows the relationship between a psychotherapist and client/patient to have therapeutic potential. In other words, for a psychotherapeutic relationship to become "therapeutic", it must possess many of the features of a supportive and nurturing extratherapeutic relationship.

Strupp (1978) defined psychotherapy as "an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes and behaviour which have

proved troublesome to the person seeking help from a trained professional" (page 3). While this definition draws attention to the notion of training and professionalism on the part of the psychotherapist, it also highlights the presence of a relationship, and a relationship situated in a particular context. Clarkson (1991) suggested:

> Relationship or the interconnection between two people has been significant in all healing since the time of Hippocrates and Galen. It seems to be one of the significant features in any major change or metanoia (page 3).

Psychotherapy is a psychosocial intervention, which intentionally utilises the powerful effects of relationship to enable purposeful change. Participants in this study located relational difficulties at the centre of their eating disorder development and subsequently placed relational support at the centre of recovery.

In Chapter Four, I explained that eight of the twelve participants discussed a range of familial factors that they perceived to be critical to the development of their eating disorders. These included examples of low levels of parental responsiveness and availability (Janice, Pamela, Rosie and Caitlin), mental-ill health or personality difficulties with one of their parents, (Emily, Bethany and Caitlin), problems in the marital relationship (Emily, Ailsa and Pamela) and parental/familial body image disturbance (Bethany, Ailsa, Rosie, Janice and Nadia). These issues were analysed further and grouped under the superordinate theme of Attachment. In addition, seven participants discussed a range of adverse life events that they believe contributed to the development of anorexia. Examples of such adverse life events include sexual abuse (Leah, Rosie, Nadia, and Anna), various personal losses (Anna, Rosie, and Bethany), physical abuse (Rosie) and forms of emotional abuse (Rosie, Emily, and Pamela). These issues were analysed further and grouped under the superordinate theme of Trauma. Finally, two of the youngest participants described the onset of their eating disorder within the developmental context of adolescence and growing up (Craig and Kate). These issues were analysed further and grouped under the superordinate theme of Identity.

In the next part of this chapter, I intend to explore how psychotherapy appears to respond to and seeks to address these difficulties and in conjunction with other

extratherapeutic factors, supports each participant's recovery. There is more discussion and examples offered in relation to the superordinate themes of Attachment and Trauma, with slightly less given to the superordinate theme of Identity. This is because the superordinate themes of Attachment and Trauma were central in more participant interviews. Although the superordinate theme of Identity was less dominant than the other two, I believe it remains a significant finding for two of the participants and I wanted to ensure this 'smaller story' was not lost or excluded from the findings.

6.2(1) Attachment and the Developmentally Needed/Reparative Relationship

> *There is a kind of food*
> *Not taken in through the mouth*
> *Bits of knowing that nourish love.*
> *The body and the human personality form a cup*
> *Every time you meet someone, something is poured in"*
>
> (Rumi, 1991, page 50).

Having interpreted selected participants' accounts of developing anorexia from an attachment perspective, I then reviewed the information they shared on psychological therapy from an attachment perspective and specifically explore the use of psychotherapy as a mechanism to address developmental deficits arising from early attachment experiences.

Research over the last thirty years has strongly argued that a child's early attachment relationships are paramount to assist the development of physiological, neural and behavioural responses to the world (Bowlby, 1988; Siegel,1999; Cozolino, 2006). Moreover, the interaction in early attachment relationships and the emotional nature of these interactions create an "implicit" knowledge base of how to live in the world, or an internal working model (Stern, 1985; Bowlby, 1988). This includes two different forms of memory: "Explicit memory involves the retention and recall of material that is consciously experienced whereas implicit memories may be acquired without awareness of their acquisition" (Grigsby et al, 2000, page 85). The emotional and physical interaction of the caregiver and infant are the foundations of the child's implicit relational knowledge. Such interactions offer an experiential template, which

is added to over and over again with on-going interactions and experiences.

It is precisely because of the possibilities arising from 'on-going interactions and experiences' that psychological therapy is curative. Developing an attachment relationship (a developmentally needed relationship) within the psychotherapeutic relationship can be important to produce meaningful change. Inevitably, this requires the psychotherapist to be practically and emotionally available to the patient/client. Amini et al (1996) suggested:

> If therapy is to be successful, this will result in the evocation in the therapist of genuine affective responses matching the patterns of the melody that the patient knows by heart. The therapist's job is to allow the duet to begin and to take up his/her place in the melody, so that the piece can gradually be directed to a different ending (page 234).

For those participants who narrate attachment difficulties in their description of developing anorexia, the relationship or "duet" with the therapist convey a particular emotional quality of safety and security, which appears to offer a "different ending", or a different relational experience from earlier relationships.

6.2(1) (a) The attachment bond in therapy: A 'Safe Haven'

Re-examining participants' storied accounts based on the superordinate theme of Attachment, I observed vivid and moving descriptions of interpersonal transactions between participants and their psychotherapists. Such descriptions are brought to life, when situated alongside previous descriptions of their early attachment relationships with caregivers. There is a profound sense that their psychotherapists were offering significant and developmentally necessary experiences, including interactions, which promote emotional regulation that ultimately affects psychoneurobiological change (Bar-Levav, 1988; Siegal, 1999; Cozolino, 2002; Wallin, 2007). Duquette (2010) suggested that the relationship in psychotherapy:

> can be a driving force in the process of changing the brain, resulting in improved ability to label and respond to internal experience, to regulate flexibly his or her emotional experience in the context of relationships, and to think realistically without the distorting influence of emotions. The therapist is thus an agent of change for a brain in transition (page 128).

I would not expect participants to describe their experience of psychotherapy in such biopsychological terms. However, their descriptions of therapy offer perspectives or insights into a therapeutic relationship that is entirely consistent with Duquette's formulation of the neuropsychological effects of psychological therapy. I shall now discuss Rosie, Janice, Pamela, Caitlin and Bethany's descriptions of their therapeutic relationship.

Rosie identified the importance of having supportive interpersonal experiences with her therapist to mediate against the abusive relationships experienced in the past. The problematic relationship with her parents increased her vulnerability to abuse and neglect by them. Pervasive low levels of warmth and care also rendered her vulnerable to further exploitation and abuse by her employer, given that her parents allowed her to live with him when she was only 15 years old.

The therapeutic factor that runs through Rosie's discussion of psychotherapy is the experience of receiving care, validation and protection. Examples included her therapist's full support in her decision to move to university and her expression of confidence in Rosie's capability to manage independent living. I think these experiences of warmth, recognition, having adult support and advice were internalised. This positive and nurturing relationship is an antidote to those earlier relationships that had been abusive and traumatic for her:

> "I think to be able to pinpoint where there has been good care in relationships, that's something that's helpful. I still hold onto that, that'll stay with me as a protection of my self-worth. You know, to say, someone really got to know me inside out, still liked me as a person and didn't hurt me. That made a huge difference to me as a person".

Furthermore, the connectedness between extratherapeutic and therapeutic factors is important. Rosie reached a point where she is able to consider leaving home, and in doing so removed herself from her abuser in order to pursue a new life at university. However, her capacity to make such significant life changes appeared to have succeeded the provision of a 'good enough' therapeutic relationship. Given Rosie's history of abusive relationships, the nurturing relationship with her therapist was developmentally needed and enabled her to internalise and integrate new relational

experiences. Having experienced a 'secure enough' relational base with her therapist, Rosie appeared to then be ready to proceed with important developmental tasks, such as expanding independence and defining her own identity, an identity not solely based on her past.

As well as receiving care, Rosie also described the importance of protection. In the previous extract, she talked about her therapist's engagement with her as "a protection of my self-worth". However, she also experienced practical forms of protection from her therapist. For example, Rosie was given her therapist's mobile telephone number and was able to contact her when required. She linked this practical arrangement to feeling "worthwhile" for the first time:

> "She wasn't the kind of counsellor that had a 'blank slate' about her. She was very personal, and she also gave me her mobile number and I was safe to contact her out of hours, right up until when she left. And I think that was reassuring, cos it felt like someone really cared and it felt like I was worthwhile for the first time".

Once more, Rosie seemed to be creating a link between her therapist's treatment of her (nurturing and protective) and a change in her own sense of self-worth. The possible mediating variable is Rosie's internalisation of her therapist's deep care: "If she cares about me, I can care about me". For me, this mirrors the same emotional and physical interactions of the mother and infant. It is the cornerstones of a child's implicit relational knowing, their internal working model.

Janice also located the development of anorexia within an insecure interpersonal relationship with parents, leading to core low self-esteem: "If they don't care about me, there must be something wrong with me". As a result, a competitive dynamic emerged between her and her siblings, particularly her sister who also developed anorexia and was described as both "cleverer" and "prettier". I think the quality of the therapeutic relationship with her therapist was crucial in addressing the developmental deficits associated with internalised conditional acceptance by her parents. Her therapist's willingness to 'go the extra mile' (when agreeing to be called to help "rescue" Janice at the local accident and emergency department) specifically attended to a developmentally needed experience of being unconditionally valued and cared for.

In turn, this allowed her to begin contemplating a less competitive relationship with herself, based on self- acceptance and tolerance:

> "And this person, it was almost like no other human beings are a burden, we just help each other. And that felt lovely and made a huge difference. So I was certainly getting better by then but the idea of true recovery was just more, entitled, self-esteem, because I'm a human being. And no matter how imperfect I am, I'm worth looking after. That to me was recovery. And being able to appreciate what this person was doing for me, it wasn't just, wasn't at all about reaching goals. Goals like, losing weight, staying thin, new advances in my career or anything like that. That wasn't what she was helping with. She didn't care (pause) well of course she cared (pause) She was helping me become more healthy and accepting compromises. It wasn't until I'd experienced that kind of bond in therapy that I realised I wanted a child"

I am struck by the connection of her relationship with her therapist and readiness to have a child. I consider this to be an expression of having received sufficient developmentally needed experiences. This would have allowed her to update her internal working model, moving to become a provider, as well as recipient of care.

Pamela's description of developing anorexia is also significant from an interpersonal perspective. This included her parents' separation, being left to live alone from the age of 14 years, believing her father "Didn't give a fuck" about her and that her mother was "in denial" about her difficulties and preoccupied with her job. In contrast, she then described her therapist as someone who "knew" her and was able to "work things out":

> "He knew what I was like, I could not play tricks on him. I think he was the only one that really worked because he was really (pause) because he was really (pause) he could just work it out. You know, he didn't just feel sorry for me".

I think Pamela's caregivers were insufficiently attuned to her needs. From such a position, she could "play tricks on people" - for example, telling her parents that she was "ready" to live on her own aged 14 years. Therefore, her observation that this pattern did not recur and repeat within her therapeutic relationship is developmentally significant. Pamela and her therapist were cultivating a developmentally needed relationship, where she required her therapist to be strong, sufficiently attuned to her needs and able to take a lead in the way a parent should ("he could work it out"). In

other words, he could be a caregiver to her. Part of the nurturing experience involved being truly valued and accepted for who she is:

> "And it was as if my opinion mattered and for years I never had that. He treated me like a normal human being. Most people just look at you as if there's something wrong with you and you can't really talk about it, because if you say to someone, "I'm screaming inside my head. I want to die" then they just say, "You're crazy. You have a condition".

She described the experience of being able to share how she really felt, without being judged or labelled negatively, as she said she had been within her family. In addition, the therapeutic relationship not only influenced her self-perception (thus improving self-worth) but altered the impact of such cognitions and affect on her self-expression.

The issue of unconditional acceptance and its effect on self-expression was also discussed by Caitlin. She articulated the importance of being able to explore and share difficult thoughts and feeling about her father. She did not feel able to discuss such feelings with her mother:

> "To be able to talk about that in kind of (pause) someone I didn't know, someone I could (pause) someone whose feelings I couldn't hurt by saying what I said, was really good as well. And it was nice to have an outlet for that like (pause) I'd never spoken about it before. We spoke a lot about (pause) my relationship with my father (pause) mainly that actually. And to have an outlet for that (pause) cause usually I would chat to my mum or my friends or whatever but then sometimes there's things I don't want to talk about. So (pause) to be really angry with people that (pause) it's hard to explain. If I was really angry with my dad, I couldn't say it to my mum. Cause (pause) she obviously doesn't agree, so (pause) I might not tell my mum that (pause) but it was good to have someone I could talk to and say that to and don't think whether (pause) if how I was feeling was alright. I wouldn't have to feel guilty for feeling the way I did."

This is an interesting issue from an attachment perspective. The Boston Change Process Study Group, (for example see Lyons-Ruth et al, 1998; Stern et al, 1998; Morgan et al, 1998) discussed the role of the primary caregivers in supporting the child to regulate his or her own emotional states. This can occur when the caregiver models being able to regulate the child's affect. This experience can then be internalised by

the developing child, creating useful memories of affect regulation. Accordingly, if Caitlin felt unable to express negative affect such as anger, or this would generally be followed by a secondary emotion of guilt, her therapist was providing a significant developmental opportunity through her ability to tolerate the participant's emotional states. The "outlet" that Caitlin referred to may have been the capacity to label and express strong emotional affect. Moreover, by internalising the therapist's emotionally tolerant stance, she is provided with new implicit memory information on the regulation of affect.

Similarly, Bethany expressed concern that people may consider her "a bad person" for the way she felt. Perhaps discussing these issues with her therapist allowed her to resolve some of the secondary guilt, resulting from her primary emotion of anger towards her father:

> "I think I always assumed that everybody would view me as a bad person for the way I felt. So just being given the permission to say that and then help to see that I wasn't so bad for feeling that. I'm not sure how it worked really but just that sort of non-judgmental, unconditional positive regard that a counsellor has to do (pause) but it works. (Laughs) Yeah, that worked for me".

From an attachment perspective, I see the use of the word "permission" as an expression of her therapist's capacity to tolerate her range of emotional states and in turn, perhaps lessen some of the secondary emotions of guilt, by internalising her therapist "non judgemental, unconditional positive regard".

6.2(2) Summary on Attachment and the Developmentally Needed Relationship

Without exception, all participants mentioned the importance of their therapeutic relationship with their therapist, whether their perceptions on developing anorexia related to the superordinate themes of Attachment, Trauma or Identity. Nonetheless, the *meaning* (if not importance) of the therapeutic relationship appears to be different for those people who narrate problematic interpersonal histories. These experiential accounts place a particular importance on the nature and quality of the therapeutic relationship.

In their discussion of the role of psychotherapy, these particular participants described the ways in which the internalisation of this new kind of relationship led to curative change, whether increasing self-worth; affect regulation or self-expression skills. The potential significance of this cannot be underestimated. If a child grows up with insecure interpersonal attachments and is offered a new, more responsive and nurturing relationship in adulthood, this offers new interpersonal and intrapsychic information. In other words, these participants are afforded the opportunity to update their relational histories with new information. This is a complex process. It is not a simple equation:

problematic early experiences + nourishing experience with therapist =
problem resolution.

However, the enduring nature of attachment processes across the lifespan allows effective therapists to provide new interpersonal and intrapsychic opportunities to their patients/clients, which can update their internal working models. As Bowlby (1988) stated, attachment is "a characteristic of human nature from the cradle to grave" (page 84). Accordingly, developmental processes can continue throughout the lifespan and the process of psychotherapy can further the processes of development that stalled earlier in the adult's life.

For participants who described trauma as a central aspect of their illness experience, I interpreted their accounts of the role of psychotherapy drawing upon the superordinate theme of Trauma.

6.3 Trauma and the Developmentally Needed/Reparative relationship

"The most damaging feelings are those that are never discussed"

(Catherall, 1992).

Participants discussed a range of adverse life events that they believed contributed to the development of their eating disorder. They not only described difficult life events, but articulated the affects of these events, and in particular, alluded to the

experience of traumatisation. They talked about how painful and troubling these incidents were. As a result, they struggled to integrate them into their autobiographical memories, a part of their 'life story'.

Participants' accounts of the role of psychotherapy in relation to trauma would suggest that it addressed traumatic experiences and their consequences within the psychotherapeutic work. Clarkson distinguished between on-going experiences that will impair developmental processes over time, as well as discrete and specific traumatic incidents that affect mental health. Traumatic incidents are more likely to require specific interventions that address the consequences of the trauma. Nonetheless, it is important to recognise that sustained trauma can inevitably have an adverse effect on developmental processes.

6.3(1) Bearing Witness

Anna, Leah and Nadia all described the importance of breaking the silence of their traumatic experiences and the importance of having a trusted other bear witness to the crimes they were subjected to. Bearing witness can be considered from different perspectives. Ullma (2006) suggested bearing witness can be "a social process that exposes a disavowed reality of evil and suffering as a distinct function of the therapist and as a curative element within treatment" (page 181). Within psychotherapy, bearing witness includes holding, containment and working through trauma, predicated on recognising the experience of the other (Poland, 2000).

Anna described the centrality of being able to acknowledge and discuss her decision to have a termination, her family's response and her subsequent grief and loss. Anna's account narrates the perception that anorexia was precipitated by her termination and maintained in part by her family's response afterwards. The meaning of the termination was significant as Anna believed she had somehow been manipulated or coerced into the decision. The perceived lack of discussion and support afterwards was experienced as highly invalidating. Accordingly, when she then discussed being subjected to a sexual assault some time later, I think this is also important from a trauma perspective. I wonder if she experienced this incident as revictimisation.

Revictimisation is a complex process. On one hand, people who have been victim to intentional trauma have a need to protect themselves. However, at the same time, experience may also have taught the victim that self-protection can be futile (Schiraldi, 2000). Alternatively, revictimisation may involve particular thought processes based on a belief system about the self, others and the world - for example, 'The reason these things happen is because of a problem with me. I am the problem'.

Anna was overwhelmed by similar negative cognitions and affects towards herself and others. These were not communicated openly or eased by interpersonal support. When Anna discussed recovery, she talked about being able to "release all that". I interpret "all that" to include the affective component of her experiences: the anger, shame and guilt she had been unable to process and integrate. Her therapist acknowledged her experiences, allowing Anna to acknowledge them to herself. I think that by accepting what she had been through and the choices she made, facilitated a process of self-forgiveness for having the termination. Anna was perhaps also able to forgive others for the influential role they had in shaping her decision. In my opinion, this process allowed recovery to take place. The importance of her individual therapy was that it provided an interpersonal context where these issues could be talked about, private experiences explained, emotions identified and the experience of anorexia formulated within her broader life experiences.

Leah had met with several psychological therapists. Despite her firm conviction that the experience of childhood sexual abuse triggered and maintained her eating disorder, she had never been able to disclose and discuss what had taken place. At the time of entering into psychotherapy with her therapist, "Tony", her father was still in regular contact with her and was actually driving her to and from all of the health care appointments. A fundamental issue was that her therapist specifically asked if she has been abused. She described her reaction on meeting her therapist:

> "He saved my life. From the minute (pause) from the first minute I spoke to him (pause) I knew things were going to change because (pause) there was just [stutter] a (pause) a certainty about him. And he, he sat me down and helped me understand everything and then we spoke about (pause) it was him that asked me if I was abused. Nobody had ever asked

me".

In her account of their therapeutic relationship, she attributed a particular status to her psychotherapist and his abilities. However, someone who has been sexually abused is likely to feel trapped and burdened with such a difficult 'secret'. Therefore, being asked directly if such a trauma occurred could understandably be experienced as an extraordinary or even transpersonal type of experience. Furthermore, I wonder if the level of trauma associated with sexual abuse and the fundamental experience of betrayal from a trusted other (her father) led to the need to believe her therapist was a strong, powerful, expert and profoundly "good" other, in order to instil hope about the future. Having made the disclosure and been believed by her therapist, they then began to engage in work aimed at securing her personal safety.

Nadia did not talk in detail about her experience of abuse within the research interview, but she was able to do this with her individual therapist:

> "For me, I never thought I'd be able to tell anyone what had happened and I didn't for years and years. I actually never thought I would say. It was a bit like, "If I don't say it, maybe I can kid on it never happened". But it doesn't work like that and it was eating away at me. But when I finally told my therapist, it felt so important that she just sat and listened. She didn't overreact, or get all upset, she just listened and said it was a terrible thing that I'd been through. That helped me a lot".

I am struck by the way her therapist acknowledged what has taken place and seemed to offer precisely what Nadia needed, both on an affective and a cognitive level. She was able to contain the participant's emotional response to the traumatic detail as well as her own and acknowledged that the participant had been treated unfairly, describing the abuse as a "terrible thing".

By bearing witness to their trauma narratives, these participants' therapists seemed to acknowledge the impact of trauma, embrace and contain their despair, whilst simultaneously offering hope that they can move on and heal, what Weingarten (2000) referred to as "doing hope" (page 399) and Flaskas (2007) suggested is "holding the balance" between hope and hopelessness (page 195). Lord (2008) suggested:

> The major goal of any good therapeutic work is to work together towards authenticity and towards helping the client fully inhabit and be enlivened in his or her life. If the client has been sexually abused as a child, he or she has been an object of someone else's life and must work towards becoming a subject in charge of his or her own life (page 125).

In the next section, I will discuss a technical intervention I consider to be regularly employed by participants' therapists to encourage this self awareness and autonomy.

6.3(2) Creating Safety

For some participants, a key aspect of the psychotherapeutic work was to negotiate and take appropriate steps to ensure the participant was safe from further exposure to physical and/or sexual abuse.

Leah's therapist adopted a proactive, pragmatic and collaborative approach to the immediate risk of further abuse to ensure her continued safety:

> "So Tony says 'Well, look, if you can't talk to him, he says, write him a letter, we'll write it down and then we'll go over it and we'll fine tune it so that (pause) it's perfect, word perfect. You know, you're not making a fool of yourself saying the wrong thing'. He says, 'We'll send it to him and that's it and you don't need to have nothing else to do with him. Because he does not deserve your love'. And see (pause) see that, for me, that's an absolute fantastic (pause) but I couldn't believe it. Ha! I can't believe he's saying that. And I felt fantastic you see after I sent that letter. That was (pause) it was brilliant".

Similarly, Rosie recalled discussions with her therapist about moving away from home and leaving her employer who was sexually assaulting her:

> "She told me quite clearly - It's going to be impossible for you to make a recovery if you continue to expose yourself to him. She also talked about her job and things and how she couldn't just sit back and allow that to happen. So we talked about my "exit strategy", and I got away and came here to start uni late September".

The type of interventions Leah and Rosie discussed are consistent with Basham and Michel's (2004) Three Phase Model of therapy with trauma survivors. Phase 1 includes establishing safety, stabilisation and self care capacities, Phase 2 involves discussion of the patient/client's trauma history and encourages a strengths-based reframing of

their narrative and Phase 3 involves supporting the individual to develop a different relationship to the trauma and subsequently self and others.

6.3(3) Metacognitive awareness: 'A thought is not a fact'

Another important issue was the way participant's thinking processes are attended to within psychotherapy. For example, some participants described the development of automatic negative thinking, such as assuming, "people must know that there's something wrong with me", catastrophising, "if I tell someone what's happened, they'll hate me", and fortune-telling, "I'll never feel good about myself again". During individual therapy, participants had the opportunity to increase awareness not only of *what* they think (the *content* of thinking) but of *how* they think (the *process* of thinking). This is the domain of metacognition and encourages focus on the internal cognitive mechanisms that control, correct, appraise and regulate thinking itself (Wells, 2000).

This is a significant therapeutic factor as it affords participants the opportunity to adopt a curious and reflective stance towards their own thinking patterns. Instead of viewing thoughts, beliefs and assumptions as an accurate representation of the external world, as something "true", participants are given the opportunity to experiment with a different perspective. For example, instead of thinking, "I am bad", therefore I must *be* bad, metacognitive awareness would observe, "I am bad" therefore I must be *thinking* I'm bad. In other words: this is a thought, not a fact. In relation to the termination, Anna described the use of written work to allow her to reflect on her thoughts as thoughts, and not facts about herself, others or the world:

> "We went through like a lot of coping strategies and stuff, made a list of things I used to like say in my head to myself when I was unwell and like to come against it obviously with all the like rational thoughts, and even when I didn't go and see C, I used to use that a lot afterwards, and I still had like all the things that we'd written down, so it was really helpful to go back and look back on, to look at the way my mind goes when I'm not ok".

In this extract, Anna was describing cognitive restructuring work in the form of identifying automatic negative thoughts and creating alternative explanations based

on evidence. However, the *process* of this type of work facilitates enhanced metacognitive awareness. It follows that if one can begin to reflect on negative thoughts as thought processes rather than facts, the corresponding level of distress will change and lessen.

Leah also alluded to her increased capacity for metacognitive awareness following psychological therapy. She specifically mentioned her attempts not to "get sucked back" by her "dark thoughts":

> "I do talk myself out of things when the dark thoughts come back. I can see that's what's happening and I tell myself not to get sucked back into that".

Nadia also talked about increased metacognitive awareness although she described it as a process where her thoughts would not be "kept inside", where she has insight that this was "going on" in her mind:

> "You know you got it off your mind, you got to talk about it if you know what I mean, it wouldn't be kept inside you, you know, you'd think about it all the time, you'd get it out and talk about it. It would feel much better realising that this was just negative stuff going on in your head".

There is some research to suggest that people diagnosed with anorexia employ particular metacognitive strategies and are less successful at using thought re-appraisal (Woolrich et al, 2008), yet it appears to be something Anna, Leah and Nadia were able to practise after their experience of psychotherapy. Metacognitive awareness originally developed from education research and has only been applied to therapeutic practice in the last ten years. It is important to note that the therapists working with these participants may not have been intentionally attempting to increase metacognitive awareness. They may have been following other models or protocols based on their training and professional background. Furthermore, it is unlikely that participants would employ this type of technical language to describe changes in their cognitive processes. Nonetheless, I believe this may have been a powerful therapeutic process offered to these participants.

6.3(4) Summary of Trauma and the provision of the Reparative Relationship

For participants who understand the development of their eating disorder as connected to previous trauma, I interpreted their accounts based on the provision of the developmentally needed/reparative relationship. Within the framework of the therapeutic relationship, this involved different tasks for different participants including taking steps to prevent further sexual and/or emotional abuse, bearing witness to and validating participants' aversive life events and working on healing strategies aimed at moving towards a more self-compassionate position. Once more, the potential benefits of these therapeutic actions cannot be underestimated. Trying to empathise with the events that participants narrate, I have a number of questions: If I had been sexually abused, what would it be like to finally be asked if I was being abused? How would I experience someone telling me that what I had been subjected to was wrong? What would it be like to have someone help me create a plan to keep me safe from this happening again? How would I feel if someone said, "This is not your fault"? I experience an emotional reaction in response to these questions involving a mixture of sadness and hope. Although the process of working through trauma within psychotherapy can create ambivalence and uncertainty, I also imagine it can be experienced by the client/patient as a 'life-line'. So when Leah said her psychotherapist "saved my life", this is what I take her statement to mean. Turning to the final superordinate theme, two participants described the development of anorexia in relation to difficulties with identity formation. For these participants, I explored on the role of psychotherapy from the perspective of the superordinate theme of Identity. I also examined this in relation to the developmentally needed/reparative relationship.

6.4 Identity and the Developmentally Needed/Reparative Relationship

Two of the youngest participants, Craig (aged 19) and Kate (aged 20) years provide accounts of developing anorexia in their teens, at 17 and 14 years respectively. These younger participants described a more recent experience both of developing and recovery from anorexia. Their experiential claims about developing anorexia are located within the developmental context of adolescence and growing up. During

analysis of this data, I identified the superordinate theme of Identity. My understanding of their perception of therapy was that it assisted with the identity struggles they encountered during their fifth psychosocial stage: identity -v- role confusion (Erikson, 1963).

There were a number of issues that required further consideration. The first relates to participants' sense-making about their psychosocial challenges, the impact of these challenges on their developing sense of identity and the way individual therapy can attend to and seek to support resolution of these issues. The second relates to the more precise nature of the developmentally needed/reparative relationship with their therapist, and specifically the way in which individual therapists can be conceptualised as Friends, or offering friendship. Finally, the third relates to the co-construction of personal identity through the process of autobiographical narration within individual therapy.

6.4(1) Identity formation: Anorexia as a transitional identity

> *"Eating disorders express our uncertainties, our buried anguish, our unconfessed confusion with identity"*
>
> (Chernin, 1986, page 36).

Craig's description of developing anorexia and recovery related to his emerging identity informed and influenced by low self-esteem and his need to establish a new identity, which would be more acceptable to himself and other people. Dietary restraint and weight loss were initially employed and reinforced by offering a sense of being able to transform the 'unacceptable' parts of himself. However, this was eventually extinguished when he began to anticipate an alternative aversive identity as a 'psychiatric patient' when admitted to hospital for treatment. At the same time, Craig gradually started to re-engage with important aspects of his life - with family members, school, work and friends. Simultaneously, he began to experience himself as being stronger and more confident.

Kate's description of developing anorexia and recovery related to the interaction between her temperamental vulnerabilities (she described herself as a highly anxious

child) coupled with environmental stressors in the form of puberty, bullying about weight and shape and negotiating the development task of separating from her parents. Whilst adolescence itself is not enough to produce a crisis with identity, McAdams (1993) suggested:

> Because of certain biological, cognitive, and social changes that do seem to occur in the adolescent years, the stage is psychosocially set for the emergence of identity as a new problem in life at this time (page 75).

McAdam continued that problems are more likely to emerge when the individual begins to notice "incongruities" between the past self and the present self. Both of these young people struggled with developmental challenges. I believe these challenges included the experience of an incoherent self-identity. As a result, I think that an illness-identity (being 'anorectic') was adopted and served as a transitional identity until such time that they were ready to continue with identity formation, as young adults, with established roles. For Craig this included acquiring full-time employment and becoming a footballer with his local amateur team. For Kate this included becoming a student and focusing on a career in nursing. For both of these young people, these opportunities expanded their social and interpersonal spheres as they developed new relationships.

Reflecting on the role of psychotherapy, both talked about acquiring new skills for affect regulation and distress tolerance, as well as managing unhelpful thinking patterns. For example, Craig referred to the use of imagery work, "safe places" to assist with distress tolerance:

> "She just spoke about a couple of things like safe places and stuff which did help you know when you did feel down and stuff like that you just could. She would go through things like that. That's the one thing that stuck out for me you know, cos you just imagine something that made you feel happy eh sorry safe, comfortable and stuff you know, that's the one that did help me".

Kate discussed acquiring skills to challenge an unhelpful thinking style:

> "So every week we used to go, like I used to get like a bigger picture of what, like she used to put things into perspective like I was really bad at just looking at, I couldn't see beyond tomorrow, whereas she used to be

> like oh K like you've got like four weeks and you could potentially like be starting university".

She gave a number of examples, in which her therapist encouraged better decision making by helping Kate to see the "big picture". I believe this relates to a thinking style associated with perfectionism as this can predispose a person's attention to fine detail, instead of more overarching goals and objectives. This can lead to problems in worrying about minutiae and losing the broader context, being unable to see the 'wood for the trees'. Kate's therapist appeared to support cognitive remediation, by assisting her to develop metacognitive awareness of her thinking style and establishing ways to address this.

As well as teaching particular skills, the nature and quality of the therapeutic relationship was also important for these participants.

6.4(2) The Developmentally Needed/Reparative Relationship: Therapist as Friend

Craig and Kate offered a variety of examples which conveyed a positive and mutually respectful relationship with their psychotherapist. When reading their experiential accounts, I started to think of their descriptions of their therapeutic relationships as friendships. Sullivan (1953) believed there was nothing more important than a close friendship, suggesting the intimacy between friends represents the pinnacle of human interpersonal experience. The realisation in adolescence that one is no longer who one was (a child), leads to a search for who one now is or will become. This search for identity is initiated in a social context, and adolescents come to know who they are through relationships in social settings. Friendships are crucial as they represent a move away from the dominant relationships of the past (for example, parents and teachers) and allow the individual to be with others who are grappling with the same questions. Erikson (1963) suggested, "It is the ideological outlook of society that speaks most clearly to the adolescent who is eager to be affirmed by his peers" (page 263).

Of course, the relationship between Craig and Kate and their psychotherapists are not peer relationships. Nonetheless, they appear to contain many of the essential qualities

or components of a friendship (what might be understood as an extratherapeutic factor within this study). Moreover, for these particular participants, this is precisely the type of developmentally needed/reparative relationship required. For example, Craig highlighted the importance of being able to openly sharing his thoughts and feelings with another person (something he had been inhibited in doing for fear of negative judgement and evaluation) and experiencing acceptance, respect and validation.

This appears to have challenged his self-perception of defectiveness ("there's something wrong with me"). He described the importance of his conversations with his therapist and how the dialogical process communicated his therapist's respect of him:

> "I honestly quite enjoyed you know coming in and talking away you know I would quite enjoy it, I think it did help me, it gave me just what I needed I felt you know, it just really made me feel respected like".

He also talked about the cathartic process of open self expression, being able to "let problems out":

> "It eh teaches you not to keep problems in, to let them out you know, to speak to somebody about it, even if its not you parents just somebody you can trust".

Craig was able to experience his therapist's genuine respect, honesty and unconditional positive regard. Over time, I believe he was able to internalise and integrate these experiences and in doing so, developed a more compassionate and respectful stance towards himself. In other words, he was supported to begin to develop a coherent and acceptable self-identity.

Kate also talked about the way her individual therapy supported her identity development, thus enabling her to leave the illness-identity behind. This included using some of the sessions to discuss and plan going to university and what would be required to allow her to achieve this goal:

> "I talked about it so much - how much I wanted to do nursing and stuff like that. So she (therapist) was actually really good, about saying we have the goals, like we sat down and she was like, 'well in six months time

> where do you want to be, like what do you want to do' or whatever, and it was always 'Oh I want to go to university, I've got this place at (named university), I really want to be able to accept it', blah blah blah".

Her relationship with her therapist appeared to be developmentally needed in that it challenged her own negative beliefs and associated role confusion. The experience of her therapist's faith in her abilities to complete her exams and study nursing at university was enormously important for her self-esteem. Kate mentioned the therapist's "trust in her" as being a turning point. By identifying with her therapist, seeing herself through the eyes of the therapist who views her as able, competent and trustworthy, her self-esteem development was significantly supported:

> "With university, she was like, You can do this! She said I was quite capable of going to university and kind of, encouraging me to see what life would be like without anorexia. I think she probably recognised at the time, that changing my environment would help a lot".

For both participants, psychotherapy provided a relationship separate from the system of parents, siblings and teachers. This relationship was based on mutual respect and honesty. It relied upon open and honest discussion and the expression of fears and anxieties. Through conversational interaction, possibilities and solutions were generated to address the causes of their concerns. In my opinion they were both actively encouraged and supported to experiment with a new self. It occurs to me that many of these qualities exist within close friendships - the sense of deep care, respect, tolerance and the benign wish to help and support. Uniquely, friendship offers these things without the biological connection that exists within family relationships.

Furthermore, the possibilities for the co-construction of identity within a friendship relationship are similar to that of a formal psychotherapeutic relationship. Through dialogical co-construction, these participants were able to experiment with identity possibilities, which ultimately allows them to clarify a preferred autobiographical narrative, which they were able to enter into within their lived experience.

6.4(3) Creating a Self in therapy

The process of autobiographical narration is a powerful one. People are able to (re)form their own self-narrative through the process of story telling. McAdams

(1993) presented a theory of human identity based on the process of storytelling, or creating our own "personal myth" (page 11). He argued that as people, we attempt to understand the nature of our life course to enable us to know who we are and how our life may be made most meaningful. In addition, he proposed that personal myths are:

> a special kind of story that each of us naturally constructs to bring together the different parts of ourselves and our lives into a purposeful and convincing whole. Like all stories, the personal myth has a beginning, middle, and end, defined according to the development of plot and character. We attempt, with our story, to make a compelling aesthetic statement. A personal myth is an act of imagination that is a patterned integration of our remembering past, perceived present and anticipated future (page 12). The same potent processes of storytelling can occur within psychotherapy (Lynch 1997), as the healing potential of personal narration offers a way to depathologise life and create a coherent life story, constructing a more acceptable and vitalising version of the self, others and the world.

If one accepts McAdams position that, "illness amounts at least in part to suffering from an incoherent story or inadequate narrative accounts of oneself" (page 33), then the role of psychotherapy in helping to dialogically co-construct a new personal narrative becomes a vehicle to influence, shape and ultimately develop personal identity. Therefore, personal identity is not merely *expressed* through personal storytelling within psychotherapy, it is actively *influenced* and *shaped by* the narrative process.

The same process is possible within autobiographical research interviews (Collins, 1998; Parr, 1998; Reissman, 1990), and thus with the participants in this study. By narrating a personal journey through illness and recovery, the selves of participants had been healed (for some transformed), as we co-constructed their recovery narratives within the interviews. Moreover, within participants' storied accounts, individual therapists were cast as benign figures of support. For some they were saviours, helpers, surrogate parents or even an older friend.

6.5 Conclusions of the role of psychotherapy in recovery from anorexia

Within this chapter, I offered examples of analysing participants' experiential claims using both common factors and therapeutic relationships approaches. I discussed the

range of psychotherapies that participants received and identified common factors, spanning support, learning and action factors that proved to be helpful. I also aimed to evidence some of the ways in which findings are informed by the method of data analysis selected, and in particular, the way in which Clarkson's (1990) therapeutic relationships model helps to generate meanings that connect the three sections of the individual interview; developing anorexia, recovery and the role of psychotherapy.

In Chapter Two, I reviewed available literature on the role of psychotherapy in recovery from anorexia, from a range of perspectives. I highlighted and discussed opposing views on the goals and tasks of psychotherapeutic work and broadly divided these into two approaches: one which seeks to promote meaning-making about symptoms and address underlying difficulties and another which seeks to alleviate physical, behavioural and psychological symptoms (see *2.6-2.8*).

Subjective accounts from this study provide detail about *both* meaning-making and symptom reduction. However interventions seem to be carefully timed to match the participant's readiness to change and the management of other important contextual matters impinging on each participant's hierarchy of needs, such as addressing immediate health or safety issues.

Underpinning all of this is the compassionate and respectful quality of the therapeutic alliance and the therapist's willingness to explore issues related to the development or maintenance of anorexia, without necessarily formulating anorexia as the key problem (as we have seen, for some participants, their eating disorder was articulated as a solution to other life difficulties). What this seems to suggest is that the participants in this study believe that their psychotherapists were prepared to allow the direction of the psychotherapeutic work to be led by the participant's beliefs, understandings, opinions and ideas about anorexia.

This study aims to explore the meanings *between* and *across* the three areas of developing anorexia, recovery and the role of psychotherapy. Findings highlight the central importance of the development of a collaborative formulation of the development of anorexia. This should be led by the client/patient's perspectives of what anorexia means to them, to those around them and the life they are living. If

undertaken sensitively, so that the recipient of psychotherapy is able to share as much relevant information as possible, this can usefully point towards the kinds of interventions that may be necessary to support recovery. It would appear that this requires different interventions for different people, based upon their unique understandings and meanings about their eating disorder.

In the next chapter, I will discuss and explore the findings from this study in more depth. In particular, I will discuss these findings in relation to the limited number of qualitative studies that explore subjective understandings of psychotherapy in the treatment of anorexia and discuss the implications of my findings for psychotherapy practice.

7 Tales from the edge: Conclusions from storied accounts of anorexia

7.1 Introduction

This qualitative study examines subjective experiences of developing anorexia, recovery and the role of psychotherapy in recovery. Subjective experiences include *what it is like* and *what it means* to suffer and recover from anorexia and *what it is like* and *how it helps* to be a recipient of individual psychotherapy. By creating opportunities to hear directly from people who have suffered from anorexia and received psychotherapy to support their recovery process, it has been possible to access subjective experiences. People who have recovered from anorexia hold valuable information on the factors that aided their own recovery, which may or may not include treatment experiences. As a psychotherapist working in the field of eating disorders, I have a long-standing commitment to learn more about the factors that support recovery, a commitment shared by many clinicians and researchers working in the field.

In this chapter I bring together the main findings from this study and discuss how these relate to existing literature. I discuss what this study adds to knowledge in the field of eating disorder research and explore the implications of the findings for psychotherapy practice and eating disorder treatment in general. In addition, I situate my findings within existing qualitative research that explores sufferers' illness, recovery and treatment experiences and highlight the distinct contribution that this study makes within this research paradigm. I also highlight the limitations of this study and make suggestions towards areas for future research.

In Chapter Two, I reviewed a broad range of literature on developing anorexia, recovery and the role of psychotherapy in recovery. This review incorporates medical, psychiatric, family interactional, psychological, psychotherapeutic and sociological perspectives. This orientates the reader to a number of central concerns, namely, significant differences with conceptual understandings of anorexia, discrepancies in how recovery is defined and measured and the inconclusive findings that arise from the small

number of studies that explore the role of psychotherapy in the treatment of anorexia (Kaplan, 2002). In addition, studies that specifically draw upon sufferers' perspectives are extremely limited. Indeed, research which explores subjective experience of psychotherapy as a treatment in anorexia is virtually non-existent, despite the NICE (2004) recommendations that psychological intervention should be a core aspect of treatment.

In addition, my review of available qualitative research identified significant gaps within knowledge production and important perspectives that are under-represented within the field of eating disorder research. This enabled me to identify the particular focus of this study. This included an examination of subjective accounts and understandings of:

1. recovery from anorexia alongside personal representations of developing anorexia in order to highlight potential meanings and understandings about the relationship between the two;
2. the psychological changes that support the recovery process. In particular, the role of professional and non-professional help in supporting the recovery process and the relative contribution of each, and
3. the particular factors that make psychotherapy helpful, including both technical and non-technical aspects of psychotherapy, such as particular therapeutic interventions and the role of the therapeutic relationship.

In Chapter Three, I addressed some of my philosophical and theoretical assumptions as researcher. In particular I explained my assumptions about the nature of lived experience and how these are represented and understood by the self and other people. I posited that lived experience is knowable to the self through thoughts, feelings, bodily sensations, perceptions, memories, and beliefs. I suggested that experience can be knowable to others through the process of representation and interpretation. I argued that narrative accounts provide a way to represent our lived experiences and are available for interpretation on both intellectual and emotional levels. In other words, we can seek to understand what an experience might *mean* to the teller as well as imagine what the experience might *feel like* for them. However, I also qualified this position by situating my phenomenological attitude within a Hermeneutic-Existential approach. This involves recognition that our observations are always made from a situated perspective.

This relates to the concept of being 'thrown' in the world – that we are 'always-already' engaged and involved in the world and in our relationships with other people. As a result, the closest we can come to understanding the lived experiences of others is through a process of interpretation, which is, in turn, influenced by our own experiences, preconceptions and assumptions – our fore-structures. There is no *essence* to be arrived at – just people making sense of their own experiences and those of others, bound by the conditions of time and place.

To elicit narrative accounts, I deployed semi-structured individual interviews which examined participants' meanings of developing anorexia, their recovery and the role of psychotherapy in their recovery process. Narrative representations were then interpreted using Interpretative Phenomenological Analysis (Smith, 1996) as a methodological guide. Interpretation led to the development of superordinate themes and a number of main findings. Table 11 provides a summary of the superordinate themes across the entire data set.

Table 11: A consolidated summary of superordinate themes from the data

Area of investigation	**Superordinate Theme**	**Related sub-themes**
Developing Anorexia	Attachment	Caring less Less to give Just like your father/mother I'm not ok, you're not ok
	Trauma	Sexual abuse: 'Inside shouting out' Loss: 'The things that changed us' Emotional abuse: 'Blamed' Physical abuse: 'Nearly blinded'
	Identity	Evaluation by peers: 'Am I ok as I am?' Separation from parents: 'Am I ready to go it alone?' Mastery efforts: 'Look what I can do'
Recovery from Anorexia	Definitions of Recovery	Recovery as destination Recovery as journeying
	Factors that Support Recovery (Extratherapeutic Factors)	Moving away from egodystonic aspects of anorexia Moving towards egosyntonic aspects of recovery
The role of psychotherapy in recovery from anorexia	Common factors across psychotherapeutic approaches	Support factors Learning factors Action Factors
	The developmentally needed / reparative relationship	Attachment: The attachment bond in therapy – a 'Safe haven' Trauma: Being witness Creating Safety Metacognitive awareness: 'A thought is not a fact'. Identity: Anorexia as a transitional identity Therapist as friend Creating a self in therapy

In Chapters Four to Six, I explored the main findings from the study. Chapter Four is devoted to findings on developing anorexia. Participants told powerful and moving stories about developing anorexia and shared particular meanings they had formulated about causation. The superordinate themes of Attachment, Trauma and Identity were identified from the data. These themes represent my interpretation of participants' underlying beliefs and perceptions about significant factors in the development of their eating disorder.

Chapter Five is devoted to findings on recovery. Participants' shared their definitions of recovery as well as their ideas about the factors that supported recovery or assisted in managing anorexia as an enduring condition. I find that recovery took place only when the issues or difficulties related to Attachment, Trauma, or Identity had shifted, altered or changed in some way. Furthermore, participants' definitions of recovery also seem to be influenced by their beliefs and perceptions about important causal and precipitating factors. Indeed participants' beliefs about whether it was and is ever possible to make a complete recovery were examined within their broader life narratives and in relation to other significant experiences that they talked about during their individual interview. This illuminates a significant participant perception: that anorexia was understood and therefore experienced as a solution for or way of managing other life difficulties. The superordinate themes of Definitions of Recovery and Factors that Support Recovery were identified from the data. These themes represent my interpretations of participants underlying beliefs and perceptions about the process of recovery.

Chapter Six is devoted to findings on the role of psychotherapy in recovery from anorexia. Common factors across a range of different psychotherapy modalities were explored, including support, learning and action factors. In addition, I observed further connections between subjective understandings of developing anorexia, the process of recovery and the way psychotherapy aided this process. I find that individual psychotherapy was perceived as helpful precisely when it appeared to address one or more of the three themes linked to the development of anorexia. By attending to or supporting the sufferer with the issues that *they believed* to be significant in developing anorexia, psychotherapy contributed to recovery. Furthermore, the finding that psychotherapy addressed issues associated with Attachment, Trauma and Identity led me to move from examining data in relation to common factors across different

psychotherapy modalities to examine the quality of the therapeutic relationship in psychotherapy and the factors that served to make the relationship helpful, healing and supportive. I find that participants' therapists appeared to be providing developmentally needed and reparative opportunities within the context of a strong working alliance. The superordinate themes of Common Factors across Psychotherapy Approaches and the Developmentally Needed/Reparative Relationship were explicated further. These themes represent my interpretation of the aspects of psychotherapy that were helpful and refer to the quality of the therapeutic relationship. Finally, while the superordinate themes regarding the role of psychotherapy in recovery were identified with a more direct influence from psychotherapeutic theory, I selected theory on the basis of its relevance and application to the experiential claims made by participants about what occurred in therapy, what they said was helpful and why.

I will now discuss my findings on participants' understandings of what it is like and what it means to suffer from anorexia.

7.2 What is it like and what does it mean to suffer from anorexia?

7.2(1) Introduction

Each participant's storied account of developing anorexia was unique. Nonetheless their narratives described a range of important perceptions and meanings about possible factors that contributed to their eating disorder. Repeatedly I listened to stories about emotional neglect, sexual and/or physical abuse, peer bullying, and problems with parental/familial relationships. Developing anorexia was never articulated as a sudden, medical occurrence. I therefore conclude that it was not experienced passively. Instead, participants shared intimate and evocative stories about suffering in other areas of their lives. Without exception, they created powerful connections between their difficult life experiences and the development of anorexia. While the 'chain of events' leading up to the eventual diagnosis differed within each individual account, the causal and temporal process of meaning-making indicates that participants' perceived that anorexia *emerged out of* or *helped to mediate* other life difficulties. As a result, participant accounts reflect

both functional and self-defeating aspects of anorexia. At some points it was experienced as a help and at other times a hindrance. I will now summarise the main findings relating to Attachment, Trauma and Identity, review these in relation to the existing literature and discuss my conclusions on developing anorexia.

7.2(2) Meanings of Attachment in developing anorexia

A range of experiences were categorised under the superordinate theme of Attachment. Participants offered examples of low levels of parental responsiveness and availability, mental ill-health or personality difficulties with one or both parents, problems in the marital relationship, and parental or familial body image disturbance. Participants shared moving accounts of experiences within their families of origin. For example, Janice told me she felt "unwanted" by her parents and that she had been born the "wrong sex". Emily said she had experienced an overly-controlling, "emotionally abusive" relationship with her mother who had mental health difficulties. Ailsa described a persisting worry that her parents' marriage was vulnerable. She thought it was her role to try to "make things better". Nadia was acutely aware that her mother held particular views about weight and shape and wanted her children to be "slim". My interpretation of these lived experiences is that they articulate challenges in some participants' attachment relationships with their primary care-givers. They reflect deficits in the participants' basic sense of psychological safety and security.

There is a significant body of research that supports possible causal connections between familial factors such as problematic infant-caregiver attachments in the development of anorexia. Findings from this study would support some of the aetiological ideas about attachment patterns and family interactional issues in anorexia, stemming back to the work of Bowlby (1958) on infant attachment, Minuchin's concept of the 'psychosomatic family' (Minuchin, 1978), as well as the ground-breaking work of Bruch (1973; 1978) and Crisp (1979; 1980) which attended to the role of the family in the development of anorexia and to the possibility of interpersonal understandings of it.

Such hypotheses have been advanced by more recent studies which explored more specific attachment patterns in the development of anorexia (O'Kearney, 1996; Ward et al, 2000) and identified either anxious attachment styles (Armstrong and Roth, 1989;

Chassler 1997) or ambivalent/avoidant attachment styles (Friedberg and Lyddon, 1996; Salzman 1997, Ward et al, 2000 and 2001; Candelori and Ciocca, 1998) in the interpersonal relationships of people who develop anorexia.

Although attachment categorisation was not a methodological aim of this study, based on my interpretation of the data, which was informed by my methodological commitment to explore participants' lived experiences of developing anorexia from within the terms of their own subjective understandings, I believe that the accounts offered by Emily, Joan, Bethany and Ailsa might be read as accounts of an anxious attachment style, while those of Pamela and Caitlin might be read as accounts of an ambivalent/avoidant attachment style.

Other studies have sought to explore why particular attachment patterns develop in the families of people who develop anorexia. Some explored issues such as parental mental health difficulties (Ward et al, 2001), parental personality issues (Steiger et al, 1996) or familial histories of disordered eating (Koubaa et al, 2008) all of which have an impact on attachment processes and parenting practices. Furthermore, some studies explored and found higher incidence of unresolved loss and trauma among the mothers of people with anorexia (for example, Ijzendoorn et al, 1996). These findings are also consistent with this study as participants discussed a wide variety of parental issues such as mental ill-health and personality factors, as well as parental or familial difficulties with body image concern and unusual eating patterns.

What this study adds to knowledge production is an insight into the ways that sufferers of anorexia directly *attribute meanings* to their illness experience. For some participants, this involves the relationship between attachment difficulties and developing anorexia.

7.2(3) Meanings of Trauma in developing anorexia

A range of experiences were categorised under the superordinate theme of Trauma. These included sexual abuse, various personal losses, and forms of emotional abuse and/or physical abuse. Three out of the twelve participants told me about historical childhood sexual and physical abuse: Leah, Rosie, and Nadia. In addition, Anna reported that she was sexually assaulted on one occasion by a neighbour. These

participants described high levels of shame associated with their bodies as a consequence, perceiving their bodies as flawed or damaged. Some talked about the deployment of dietary restriction and weight loss as a means of indirectly communicating distress to other people.

Other participants narrated a variety of personal losses prior to the onset of their eating disorder. This included marital separation and divorce for Pamela and terminating a pregnancy for Anna.

These findings are consistent with other studies which conclude that people who develop anorexia are also likely to have experienced trauma or some form of adverse life experience prior to the onset of the eating disorder. For example, studies which have found a relationship between sexual abuse (Rind et al, 1998; Smolak and Murnen, 2002), physical and emotional abuse and/or neglect (for example, Kent et al, 1999; Mazzeo and Espelage, 2002), as well as other forms of losses (for example, Brown and Harris, 1978; Schmidt et al, 1997) support the experiential claims of participants in this study.

Not only do they shared experiences of trauma and losses, but illuminated the ways in which they directly *attributed* such experiences to the development of anorexia.

7.2(4) Meanings of Identity in developing anorexia

A range of experiences were categorised under the superordinate theme of Identity. These included participants' increased concern about how their peers perceived and evaluated them, how they negotiated the separation process from parents and the deployment of weight loss and dietary restriction as expressions of personhood, and in particular expressions of self-mastery. Craig and Kate described a range of experiences related to Identity. Firstly, both were teased about their appearance, including their weight and shape. They acknowledged the impact this had on their self-confidence at this "tender" age. Also, both were involved in the developmental tasks associated with separating from their parents. Craig was getting ready to leave school and focus on work and Kate was considering going to university. Both were trying to manage the transition between their sense of belonging to their families of origin and towards a broader network of relationships, with an increased emphasis on peer groups.

These findings are consistent with other research which explores the importance of peer evaluation in adolescence, increased body image concern in young people and the use of weight lose practices as a means of exercising self-mastery and control (Derenne and Beresin, 2006). Physical appearance has become a powerful aspect of self-evaluation in young people that contribute to difficulties with self-esteem and associated developmental tasks with identity-formation (Katsman et al, 2004; Harrison, 2000).

These findings also support Crisp's suggestion that growing up and separating from parents' presents an "existential challenge" to the developing adolescent (Crisp, 1980, page 48). This can result in feeling overwhelmed, leading to a "flight back into psychobiological childhood" (Crisp, 1974, page 530). For Craig and Kate, anorexia seemed to slow this developmental process down, providing them with additional time to negotiate such tasks. Providing a metaphorical brake, it allowed them to manage the speed with which they moved towards the experience of adulthood.

This study illuminates the ways in which a young person might hold particular beliefs about the function of their anorexia and specifically some of the ways that anorexia can assist a young person in negotiating the complex developmental tasks involved in the maturational process.

7.2(5) Conclusions on subjective experiences of developing anorexia

Participants in this study narrated the development of anorexia in the context of other significant life events and difficulties. As active meaning-makers, I conclude that participants were attempting to create an understanding of their world by placing their own meanings onto the difficult life events they faced. Their storied accounts represent "contingent narratives" (Bury, 2001) that elucidated participants' beliefs, assumptions and perceptions about the origins and causation of anorexia.

When first hearing their storied accounts during the interview and later reading them as part of the data analysis process, I was struck by the descriptions of self-induced starvation, which appeared to be deliberate and intentional. Indeed participants communicated as active agents rather than passive subjects within their experience of

anorexia.

The precise causes of anorexia remain unknown and it is not within the scope of this study to generalise or infer that participants' challenging experiences *caused* anorexia per se. However, this study illuminates some of the powerful meanings that a group of sufferers' attribute to their life experiences and the ways such difficult occurrences affected their beliefs systems, resulting in more critical, self-defeating and disaffected perceptions of the self, other people and the world. These critical, self-defeating and disaffected perceptions are then expressed through their accounts of developing anorexia.

In addition, participants' storied accounts also exemplify "moral narratives" (Bury, 2001). Moral narratives assume that significant personal occurrences, such as developing an eating disorder, arise in relation to particular moral and socio-cultural conditions. Accordingly, when participants described painful experiences especially those related to abuse, neglect or ill-treatment by another, the causative links created though the storytelling process, speak to the consequences of people inflicting harm on others and the costs of this on peoples' health and well-being. For example, that four participants disclosed being victims of sexual crime when asked about developing anorexia illuminates the emotional consequences of sexual abuse, of which, anorexia may be one. In other words, participants' placed both experiences, in storied terms, on the same page. These narratives caution the reader that the ill-treatment of others can have devastating consequences. Anorexia is embodied devastation as the emotional costs of abusive experiences appear to be experienced and expressed through the body.

I will now discuss participants' understandings of what it is like and what it means to recover and the significance and implications of their subjective understandings about developing anorexia on their sense-making about recovery.

7.3 What is it like and what does it mean to recover from anorexia?

7.3(1) Introduction

Participants' narrative accounts of recovery are also unique and sit meaningfully alongside their account of developing anorexia. When asked about recovery, participants offered definitions of it and then shared their perceptions of the factors that supported their own recoveries. I categorised these issues under the superordinate themes of Definitions of Recovery and Factors that Support Recovery. I will summarise the main findings relating to Definitions of Recovery and the Factors that Support Recovery, review these in relation to existing literature and discuss my conclusions on recovery from anorexia.

7.3(2) Definitions of Recovery

Participants defined recovery in two main ways. Some believed it was possible to make a complete recovery and I interpreted these accounts of recovery as a metaphoric Destination. This Destination signals the end of illness. Other participants did not believe it was possible to make a complete recovery and said anorexia was either an enduring difficulty, or something that might come back. I interpreted these accounts of recovery as a metaphoric Journeying. This Journey is an on-going process, characterised by searching for, rather than finding, recovery.

Anna, Caitlin, Joan, Craig, and Bethany defined recovery as a Destination. Nadia, Rosie, Kate, Emily, Pamela and Leah defined recovery as Journeying. Interestingly, Ailsa paradoxically described it as both an on-going process and a final destination.

Within the eating disorder literature there are significant difficulties with conceptualisation and measurement of recovery. This study also finds different definitions of recovery within a small research sample. Historically, recovery focused on physical criteria, such as weight restoration and menses (Morgan and Russell, 1975), with behavioural indices (Bulik et al, 2000; Field et al, 1997, Matsunaga et al, 2000;

Strober et al, 1997) and psychological factors (Couturier and Lock, 2006; Strober et al, 1997) added later. However, recovery rates can vary significantly depending on the method employed (Couturier and Lock, 2006) and the lack of unanimity in defining what criteria should be used to describe what recovery actually is hinders attempts to draw meaningful generalisations from available studies (Herzog et al 1993; Pike, 1998; Jarmen and Walsh, 1999; Tozzi et al, 2003; Bell, 2004; Noordenbos and Seubring, 2006; Berkman et al, 2007).

Within this study, all participants said that they continued to experience some concerns relating to weight and shape concerns (see Appendix 5 for EDE results). I conclude that participants created subjective thresholds for recovery. For some, recovery did not require a complete absence of physical, behavioural and psychological indices. As a result, they were able to experience weight and shape concerns from time-to-time, yet define themselves as recovered. For other participants, recovery required elimination across all three indices. As a result, recovery was conceived as a process of managing their psychological concerns and carefully ensuring these did not influence behaviours that might result in deterioration in physical health.

7.3(3) Extratherapeutic Factors that Support Recovery

Recovery was influenced by different motivations. Firstly, recovery involved a desire to Move Away from the negative consequences of anorexia. For example, participants described beginning to see themselves unfavourably as a result of having anorexia - as Ailsa said, like someone "not getting it". They worried it would affect current or future relationships and impair opportunities to have children. They said it might impair work and career prospects, as well as more practical opportunities, such as being financially independent. Joan was also worried it might lead to developing bulimia, which was something she was particularly fearful of.

Secondly, recovery involved a process of Moving Towards particular things. It included reaching and attaining a range of life goals and developing a positive self-identity. For example, participants talked about moving towards positive relationships. This included sustaining current relationships and/or wanting to invest in securing new relationships in the future, such as friends, partners, children and colleagues.

7.3(4) Conclusions on what it is like and what it means to recover

Participants in this study storied their recovery process in relation to their accounts of developing anorexia. They were told like the 'next chapter' in their autobiography. It became apparent that those participants who narrated more problematic attachment histories and/or those who had been subjected to particular trauma, such as sexual and physical abuse were more likely to believe that complete recovery was not possible (recovery as Journeying). On the other hand, participants who had not experienced such sustained and intentional forms of abuse and neglect tended to believe a complete recovery was possible (recovery as Destination).

I conclude that participants' storied accounts of recovery exemplify "performative narratives" (Langellier and Peterson, 2006). Performative narratives acknowledge that a story comes from a 'self' with a past, who seeks to involve, influence and perhaps even move the present or future audience. It speaks of how the teller of the story wishes to be *known*, which inevitably means that some of what is said may be false, untrue or misremembered (Riessman, 2003; 2005).

Participants in this study were aware of the central importance of recovery as an area for exploration. As people who 'had recovered' (according to inclusion criteria for this study), I imagine this will have influenced the creation of their recovery autobiographies. For example, I imagine participants' thinking: What does this recovery story say about me? What do I want it to say? How to I want people to think and feel about me? Their accounts may also be influenced by what they thought I might want to hear as researcher, what the examiners of this thesis might want to see or read, or indeed how they wished to be understood by a wider audience, including other sufferers, carers or people working in the helping professions.

For participants who narrated recovery as Journeying, I interpret that they were performing a narrative about being a Survivor. For these participants, recovery was an on-going process. They continued to navigate the illness terrain and sought to find ways to manage it. These stories are cautious, modest yet brave. For participants who narrated recovery as a Destination, I interpret that they were performing a narrative

about being a Conqueror. For these participants, they had traversed across a complex illness terrain and finally reached their destination. Victorious, they had overcome all of the challenges and hardships anorexia had thrown in their paths. These stories are hopeful, optimistic and ultimately triumphant.

While experiential accounts do not offer an unchanging reflection of what occurred to the participant, both the content and the way it was told, offer valuable insights into the narrator's beliefs, perceptions, and understandings of their experience. They also signpost the reader as to how these participants might wish to be known: as people with courage, strength and resilience.

This study contributes to knowledge by offering an understanding of subjective thresholds for recovery and the criteria that an individual might draw upon to help inform their personally-defined recovery status. It also illuminates subjectively-created attributions between developing anorexia and recovery and the factors that help sufferers with their recovery process.

I will now discuss participants' accounts of the role of psychotherapy in recovery from anorexia. I will review the role of psychotherapy as part of the overall recovery process and the ways in which psychotherapy attended to the issues related to developing anorexia.

7.4 What is the role of psychotherapy in recovery from anorexia?

7.4(1) Introduction

Knowing that people in Scotland receive a range of different psychotherapeutic approaches, I used this study to focus on the common factors across all of the different psychotherapies that participants had received. I hoped to better understand, at least for this particular group of people, what had been therapeutic and why. Accordingly, participants' descriptions of the role of psychotherapy were initially analysed using common factors in psychotherapy associated with a positive outcome (Grencavage and

Norcross, 1990). This enabled me to explore their accounts in relation to a range of support, learning and action factors within psychotherapy and I was able to find numerous examples (see Table 10).

However, within participants' accounts, I observed an experiential link between their unique perceptions about why they developed anorexia and the factors that supported them to eventually recover. As I analysed the data in more detail, I found it increasingly problematic to separate their accounts of psychotherapy from their broader stories about becoming ill and their eventual recovery. In other words, it seemed to be unhelpful to try to separate the part from the whole. Without exploring the role of psychotherapy in the context of participants' entire narrative, I was concerned that the *significance* of the identified therapeutic factors might be lost.

One of the most striking features of participants' storied descriptions of psychotherapy was the centrality of the therapeutic relationship with their therapist. Using the common factors approach to psychotherapy experiences as a framework for deeper levels of interpretation, I initially coded this as a support factor. However, mindful of participants' beliefs about the interpersonal influences both in developing anorexia and recovery, I was concerned that this coding would potentially minimise the central role of the therapeutic relationship. Indeed, it seemed to me that for participants in this study, the therapeutic relationship was the primary therapeutic factor. This led me to consider why this might be the case, especially in light of their storied accounts of developing anorexia. I re-examined the data set on the role of psychotherapy and began to see the significance of particular kinds of therapeutic transactions and interactions. I saw these opportunities to engage in new and different interpersonal and intra-psychic interaction as a way to meet developmental deficits or repair earlier interpersonal injuries.

This resulted in a move from the common factors approach across onto participants' experience of the provision of specific types of therapeutic relationships, namely the experience of what Clarkson (1990) described as the working alliance and developmentally needed/reparative relationship. I will now summarise the main findings relating to the developmentally-needed/reparative relationship, review these in relation to existing literature and discuss my conclusions on the role of psychotherapy in recovery from anorexia.

7.4(2) What is it like and how does it help to be a recipient of psychotherapy?

A range of experiences were categorised under the superordinate theme of the Developmentally Needed/Reparative Relationship. Without exception, all participants mentioned the importance of the therapeutic relationship with their therapist, whether their perceptions on developing anorexia related to the superordinate themes of Attachment, Trauma or Identity.

For participants who described challenges within their attachment relationships, I interpreted their accounts of the role of psychotherapy in recovery based on the provision of the developmentally needed/reparative relationship. I heard participants' describe the internalisation of a new kind of relationship with their therapist which led to curative change. This relationship was characterised by care, protection and nurturing of the sufferer. It helped to improve self-expression skills, the capacity for affect regulation and led to an increase in self-worth. The potential significance of this cannot be underestimated.

If a child grows up with insecurity in their interpersonal attachments and is offered a new, more responsive and nurturing relationship in adulthood, this offers new interpersonal and intrapsychic information. In other words, my interpretation is that these participants were afforded the opportunity to update their interpersonal histories with new and important relational information. Developmental processes can continue throughout the lifespan and the process of psychotherapy for these participants appeared to address developmental stages that had stalled earlier in the participant's life.

For participants who connected the development of their eating disorder with previous trauma, I interpreted their accounts of the role of psychotherapy based on the provision of the developmentally needed/ reparative relationship. This kind of therapeutic relationship was evidenced by the important tasks that were undertaken. This included taking steps within therapy to prevent further sexual and/or emotional abuse from taking place, bearing witness to and validating participants' painful life events and working on healing strategies aimed at alleviating shame and guilt and enhancing self-compassion.

For participants who connected the development of anorexia in relation to difficulties with identity formation, I examined their accounts of the role of psychotherapy in recovery in relation to the developmentally needed/reparative relationship. The two youngest participants' offered examples of the ways in which individual therapy attended to and supported resolution of some of their challenges with identity formation.

These participants had struggled with a range of interpersonal challenges within their peer groups, yet described the relationship with their therapist like Friendship. They talked about having a relationship outside of the family unit, characterised by intimacy, trust and mutual respect. These qualities are particularly meaningful when considered in relation to their earlier descriptions of relationships with peers, which were characterised by judgment, conditional-acceptance and competition. Finally, given the developmental stage of these participants, I further interpreted that they were given the opportunity to dialogically co-construct their sense of self through the process of autobiographical narration within individual therapy. In other words, to explore who they are/who they are not, through their storytelling processes within therapy. Within their self-authored story, they stopped being ill people and were transformed into young adults with potential to succeed with their goals. For these participants, I conclude that their developing sense of self was pliable and this was utilised by their therapist to help shape and reform personal beliefs which were self-esteem supporting.

When I reviewed current literature on the role of psychotherapy in recovery from anorexia, I found that the goals and tasks of psychotherapeutic work were broadly divided into two approaches: one which seeks to promote meaning-making about symptoms and address underlying difficulties and another which seeks to alleviate physical, behavioural and psychological symptoms. Findings from this study indicate that psychotherapy can attend to *meaning-making and symptom reduction*. However, for participants in this study, interventions seem to be carefully timed to match the participant's readiness to change and the management of other important matters impinging on each participant's hierarchy of needs, such as addressing immediate health or safety issues. Underpinning this was the compassionate and respectful quality of the therapeutic alliance and the individual therapist's willingness to explore issues related to the development and/or maintenance of anorexia, without necessarily formulating

anorexia as the key problem. I conclude that participants in this study believed that their psychotherapists were prepared to allow the direction of the psychotherapeutic work to be led by the participant's beliefs, understandings, opinions and ideas about anorexia.

7.4(3) Conclusions on the role of psychotherapy in recovery from anorexia

Participants' accounts of the role of psychotherapy in recovery were based upon their beliefs and perceptions about developing anorexia and recovery. For all participants, psychotherapy had a role in recovery. For most it played a significant role and for Leah it was articulated as the sole recovery factor: her therapist "saved" her life.

I conclude that participants' storied accounts of the role of psychotherapy exemplify "progressive narratives" (Robinson, 1990). Progressive narratives move towards the tellers' valued personal goals, such as overcoming a vast array of personal difficulties and reaching or achieving a different self-identity in light of those experiences. Ultimately, these narratives present the teller in a more positive light - as people who have overcome hardship, people who are Survivors and Conquorers. In addition, these narratives celebrated the value and importance of the individual therapists. Therefore, when interpreting their experiential accounts of the role of psychotherapy, not only did I hear descriptions of helpful common factors and types of therapeutic relationships, I also heard sincere expressions of gratitude to their therapists. Their accounts offer validation of psychotherapy as an approach and of the people who delivered it. They are private expressions of gratitude in a public domain.

7.5 Methodological Conclusions

7.5(1) Introduction

I will now review the research methodology deployed and the implications of my methodological choices for the study. I will discuss the data collection method, access and recruitment strategies, data analysis and the presentation of findings.

7.5(2) Data Collection

The objective of this study was to gather data in the form of subjective experience about a number of *specific* areas, namely developing anorexia, recovery and the role of psychotherapy in recovery. As a result, I elected to construct and implement the use of a semi-structured individual interview schedule to facilitate an interaction that generated detailed experiential accounts of each of these particular areas of inquiry. The interview schedule was constructed with the assistance of a role-play with three colleagues and a focus group with potential participants.

The questions selected were deliberately open and expansive and sub-questions were created as prompts to encourage and support participants to offer more detailed information when required. The interview was divided into three main parts. During the first part, participants were asked to discuss what happened when they developed anorexia. Participants were also asked for their views on factors that may have triggered their illness as well as ideas on what may have caused their eating disorder. During the second part of the interview, participants were asked what had helped them with recovery. During the final part of the interview, participants were asked to explore the role of psychotherapy in their recovery from anorexia. They were asked if they thought it had aided their recovery. Participants were invited to explain how they believe psychotherapy worked, what was most helpful, what aspect made the biggest difference, and if there are aspects of their psychotherapy they continue to use to sustain recovery.

In the majority of interviews, information was volunteered spontaneously as participants narrated their personal accounts. However, in some interviews, information was generated through a more interactive conversation. The interviews yielded a large quantity of data, which was rich, descriptive and evocative. Participants generously shared their subjective experiences. I believe this indicates that the use of a semi-structured interview was useful and successful in eliciting storied accounts about particular aspects of the lived experience of anorexia.

As far as I am aware, none of the participants experienced distress as a result of participating and none took up the invitation to have a debriefing meeting after their

interview. I conclude that participants valued having an additional opportunity to re-author their lived experience of anorexia within the research context. All told me they felt positive about taking part and hoped their participation would contribute to knowledge production and ultimately help current and future sufferers.

7.5(3) Access and Recruitment

To access participants from across Scotland, information about the study was sent to and disseminated by a range of healthcare, education and voluntary organisations, as well as a local newspaper serving an area in the west of Scotland. I adopted a phased approach to recruitment over an eighteen month period to ensure I was able to meet participants promptly after they responded to the advert. This recruitment strategy generated 18 enquiries in total. From these enquiries 12 participants were recruited to take part in the study. This recruitment strategy resulted in a sample of people from across Scotland. The sample comprised eleven women and one male and a broad age range.

They had different numbers and lengths of illness episodes, varying time periods in recovery and had received a range of different forms of psychotherapy from a variety of mental health professionals. Not all participants were Scottish, but all had received psychotherapy in Scotland. I conclude that this sample were able to offer a range of experiences of developing anorexia and recovery. They were also able to provide subjective information on the receipt of psychotherapy within a Scottish context.

Participation involved two face-to-face meetings. The first meeting provided an opportunity to explain the study in more details, answer any questions and establish if the potential participant met the inclusion criteria by administering the Eating Disorder Examination (Cooper and Fairburn, 1987). The second meeting involved undertaking the individual interview. The attrition rate was low with only one participant deciding not to take part after our initial meeting. I conclude that the initial meeting and the focus group (for those who had this opportunity) helped to develop the research relationship prior to the individual interview. I met participants in a range of venues, including the university, my place of work, their place of work, their homes and in a hotel.

I further conclude that meeting in a place that participants preferred contributed to a more relaxed and comfortable atmosphere and led to the provision of such rich data.

7.5(4) Data Analysis

There is no single method for undertaking IPA (Smith, 2007). Nonetheless, an IPA methodology follows an iterative and inductive cycle which draws upon a number of strategies.

I started by analysing the experiential claims, concerns and understandings contained within the transcript of each participant's interview. Principal sentences were highlighted from the text and filed in NVIVO (QSR International, 2007). Across all 12 interviews, I recorded 132 'principal sentences' related to developing anorexia, 112 related to recovery and 87 related to the role of psychotherapy in recovery.

Secondly, data was tabulated to move from an analysis of experiential understandings towards the identification of superordinate themes that crossed the boundaries of each individual interview. The superordinate themes connected with developing anorexia, recovery and the role of psychotherapy in recovery are discussed in *7.2-7.4*.

Central to an IPA methodology was my commitment to make my own perceptions, conceptions and processes transparent, what Heidegger defines as fore-structures. Accordingly, I created a 'dialogue' between my fore-structures as researcher, and the data. I shared some of the main influences on the fore-structures I initially brought to the data analysis process, including my training in integrative psychotherapy and more recently working within a multi-disciplinary team within a specialist eating disorders inpatient setting. Moreover, as data analysis progressed, the fore-structures I brought to the analytic process were influenced by early episodes of data analysis. For example, analysis of recovery was influenced by my analysis of developing anorexia and analysis of the role of psychotherapy was influenced by earlier analysis on developing anorexia and recovery.

The process of data analysis was significantly influenced by the hermeneutic cycle. I examined each participant's interview seeking to get close to their lived experience by

paying attention to their experiential claims. I then examined each of the three main areas using a range of theoretical models, which reflect some of the psychological knowledge I brought to the data analysis process. To examine accounts of developing anorexia, data were examined in terms of Lask's model of predisposing, precipitating and perpetuating factors (Lask, 2000). To examine accounts of recovery, data was examined using Lambert et al's model of extratherapeutic and therapeutic factors in recovery (Lambert et al, 1986). To examine accounts of the role of psychotherapy, this involved initially analysing data in terms of Grencavage and Norcross's list of positive factors in psychotherapy associated with a positive outcome, known as common factors (Grencavage and Norcross, 1990).

As researcher, I engaged in an iterative process, moving backwards and forwards between the full transcript to single extracts and between individual interviews and the complete oeuvre. I discovered that it was not possible to interpret single extracts without drawing upon the complete text and vice versa, each being informed by the other. Knowing what participants had said about their experiences of developing anorexia, I started to consider *why* they may have found particular aspects of psychotherapy useful based on their earlier narrative accounts of developing anorexia. Given the central place given to interpersonal factors in developing anorexia, I became increasingly curious about the nature and quality of their therapeutic relationship with their psychotherapist and the potential significance of this. As a result, as data analysis progressed, I made a decision to re-examine data on the role of psychotherapy in recovery based upon their experiences of the provision of specific types of therapeutic relationships, namely the experience of the working alliance and developmentally needed/reparative relationship (Clarkson, 1990).

My epistemological position is informed by a Hermeneutic-Existential approach to phenomenological enquiry. I have sought to explore the nature of what is going on during the lived experience of developing anorexia, recovery and psychotherapy, rather than to encapsulate these experiences in finite terms. I conclude that participants created meanings about their lived experience of anorexia in relation to their context and I then interpreted those understandings in relation to the research context. All of this was mediated through the inevitable subjectivity of both parties.

The decision to order and analysis the data using specific theoretical models presented particular challenges. The danger of adopting this analytic procedure was that I might impose these models on that data resulting in an overly-deductive process, stifling opportunities for important information to be gathered inductively. However, holding this issue mindfully during data analysis encouraged me to maintain an open analytic attitude, being prepared to look, listen, think and feel.

Data were organised so that findings could be traced back through the data analysis process. All twelve interviews were transcribed and copies of transcripts were given to both supervisors, providing them with a detailed understanding of the experiential accounts offered by all twelve participants during individual interviews. In addition, copies of completed data analysis charts were reviewed by my supervisors. This created openness and transparency about the ways in which analysed data linked back to their original source, allowing for further reflection and critical analysis of my engagement with the data.

The creation of an autobiographical narrative is not a straightforward process, where the teller offers a clear window into their subjective experience. For example, my descriptions of each participant's experiential account represent a co-constructed, context–specific narrative. Firstly, each participant's story was based on particular questions (structured through the semi structured interview), by a researcher (who some participants had some relationship with outside the research context), in a particular place and time (in their home, at the university, at their place of work, in my office, in a hotel) for a particular purpose (to engage in qualitative research about sufferers' experiences of anorexia). The audio recording equipment placed between us served to remind the teller of a potential wider audience, who will hear the story, or a version of it at a later date. These powerful contextual factors will have had a significant bearing on what was said. Each participant had the opportunity to decide how they wished to portray themselves.

While much of the content of the story may remain over time, the emphasis of certain issues or telling of them inevitably changes as an adaptation to context. For example, how might responses have altered if I were asking the questions to create an article for publication in a glossy magazine? How might they have changed if I was also a sufferer?

Within the research interview, we were drawing upon the story created in therapy, and in doing so another story was created and told: the therapy narrative was reworked and translated into a research narrative. Secondly, interviews were analysed and made sense of in a particular way by a researcher who both works in the field of eating disorders and is doing this research as part of a PhD. The impact this had on data analysis may be as significant as the way each participant's story was told. In participants' narratives, I heard the stories of the numerous people I have worked with in individual therapy. As I listen to the audio recording, I heard their voices as well as those of the twelve participants. Furthermore, I imagine a range of future audiences, including the examiners who will read this thesis, my colleagues and professional peers, the participants, as well as other sufferers. In summary, the story produced within a research context is not inevitable, and depends upon and is influenced by immediate and future audiences.

The conclusions from this study therefore reflect the interpretations of both parties - the participants' interpretation of their own experience and my interpretation of participants' understandings of their experiences. I believe this reflexive attitude and the transparency of the methodological procedure contributes to the credibility and trustworthiness of this study.

7.5(5) Presentation of the data

In Chapters Four to Six, I present the findings on developing anorexia, recovery and the role of psychotherapy in recovery. Findings are presented thematically with explicit reference to and discussion of the theoretical models I adopted to make sense of the data. This decision has the advantage of pulling together the experiences of each participant, enabling an exploration of areas of sameness and difference between participants' experiential accounts and points of convergence and divergence in my interpretation across the entire data set.

In Chapter Six, I subject the data on the role of psychotherapy in recovery to analysis using two different theoretical models. I decided to share the methodological shift with the reader. I believe this helped to illuminate the ways in which findings within qualitative research are significantly influenced by the method of data analysis. I wanted

to provide an opportunity for the reader to get closer to the interpretative process and in turn, be able to make his or her own judgements on the findings.

7.6 Implications of the findings for psychotherapy practice and contributions to the field of knowledge

7.6(1) Contribution to knowledge

This research adds to a small number of studies which explores personal experience of anorexia. These include studies which examine recovery from anorexia from subjective perspectives (Beresin et al, 1989; Hsu et al, 1992; Pettersen and Rosenvinge, 2002; Tozzi et al, 2003; Woods, 2004; D'Abundo and Chally, 2004; Weaver et al, 2005; Lamoureux and Bottorff, 2005; Keshi-Rahkonen et al, 2005; Nilsson, 2006; Federici and Kaplan, 2008), those which investigate service-user experiences and opinions of treatment (Yager et al,1989; Newton et al, 1993; Rorty et al, 1993; Clinton et al, 2004; Halverson and Heyerdahl, 2007), a smaller number which focus specifically on psychotherapy in the treatment of anorexia (Beresin et al, 1989; De la Rie et al, 2008; Whitney et al, 2008) and those which explore subjective accounts of developing and living with anorexia (Tozzi et al, 2003; Holliday et al, 2005; Higbed and Fox, 2010; Tierney and Fox, 2010).

This study makes a distinct contribution to knowledge and this is discussed in relation to the meta-synthesis of existing literature which explores recovery from sufferers' perspectives and subjective experiences and opinions of treatment, including psychotherapy, covered earlier in *2.5* and *2.7*.

Reviewed alongside existing literature which explores recovery from sufferers' perspectives, findings from this study are consistent with the overarching themes that I identified through an analysis of this small collection of work. In *2.5*, I identified the following themes across these studies: Accepting anorexia as a difficulty; Readiness to change; Professional support and Non-professional support. These themes also resonate within my research. However, I would suggest that findings from my research go some way to respond to the important questions that these earlier studies raise, particularly those related to *how* sufferers' achieve the psychological changes that enable recovery,

what makes psychotherapy helpful and how it works and the ways sufferers' accounts of recovery relate to their accounts of becoming unwell.

Reviewed alongside existing literature which explores subjective experience and opinion of treatments, findings from this study illuminate the views of a number of ex-service users and specifically their opinions of treatment characteristics (the helpful components of psychotherapy) and highlight the relationship between service-user satisfaction with treatment characteristic and outcome. Findings from this study support the broad theme that sufferers' tend to value the therapeutic alliance with members of their treatment team and are less satisfied with treatment elements aimed at coercively restoring physical health if they are not ready to do so. However, I would suggest that findings from this research represent an investigation of significant areas that these earlier studies did not examine. In particular, this study explores the views and opinions of sufferers of anorexia on their experiences of a range of models of psychotherapy, examines what these recipients of psychotherapy find more or less helpful, gathers more detailed information about what occurs within therapy and elucidates if there are particular commonalities or shared therapeutic factors that exist across a range of psychotherapy approaches.

Readiness to change involves the premise that recovery can only take place when the sufferer is sufficiently motivated to do so. Motivation can be influenced by a range of factors that create turning points in the sufferer's subjective beliefs, understandings and meanings related to anorexia. These psychological shifts enable the sufferer to begin to contemplate change. For example, there might be positive factors that assist the sufferer to leave anorexia behind (Beresin et al, 1989; Hsu et al, 1992; Pettersen and Rosenvinge, 2002; Tozzi et al, 2003; D'Abundo and Chally, 2004; Nilsson et al, 2006; Woods et al, 2007; Federici and Kaplan, 2008), as well as creating distance from unhelpful factors (Beresin et al, 1989; Hsu et al, 1992; Federici and Kaplan, 2008). Through my analysis of the factors that assist participants to Move Towards the egosyntonic aspects of recovery as well as Move Away from the egodystonic aspects of anorexia, I highlight a unique set of advantages and disadvantages involved in participants' decisional balance about recovery and ultimately the factors that 'tip the balance' towards change and healing. When I refer to the factors that 'tip the balance' towards recovery, I find that these include non-professional support, what I define as Extratherapeutic factors. In

other words, the aspects of everyday life and that helped the participants in this study to create and sustain a life worth living beyond anorexia.

In my presentation of the factors that assist participants to Move Towards recovery, I offer personal examples of the ways in which this group of sufferers began to establish a vision of life beyond anorexia's grip, which contributed towards their perception of recovery as a positive, meaningful and egosyntonic endeavour. Examples spanned the desire to maintain important interpersonal relationships, such as those with spouses, partners, parents, siblings and friends. It also involved the desire to access new opportunities, new experiences and new relationships in the future, such as moving to a new area, beginning a new course or job and being established within a new peer group. These opportunities provided a context within which to establish a new identity – one separate from an identity as an anorexia-sufferer.

In my presentation of the factors that assist participants to Move Away from anorexia, I offer personal examples of the ways in which this group of sufferers began to perceive anorexia as life-limiting. Accepting anorexia as a difficulty involves redefining it as life-limiting as opposed to life-enhancing and has been found to be an important factor in other studies (Pettersen and Rosenvinge, 2002; Tozzi et al, 200; D'Abundo and Chally, 2004; Lamoureux and Bottoroff, 2005; Weaver et al 2005; Keshi-Rahkonen et al, 2005; Federici and Kaplan, 2008). In this research, examples include an increased concern about negative judgements by significant others, the risk of developing another type of eating disorder, a shift in perception that anorexia controls the sufferer as opposed to the sufferer being in control of it, a heightened awareness of the risks anorexia places on important relationships and the limitations anorexia can place upon achieving academic goals. Accepting anorexia as a difficulty also facilitated one participant to leave an abusive relationship.

These exemplify changes in the way anorexia was subjectively perceived and illuminates some of the personally meaningful factors that assisted each of the participants to begin to accept anorexia as a difficulty and consequently something they wanted to change. In other words, I find that accepting anorexia as a difficulty (and the insight which precipitates such acceptance) is inextricably linked to the issue of motivation as acknowledging the existence and negative consequences of anorexia is an important

precursor to participants' wish to change.

This research also finds that professional supports are important in promoting recovery, what I define as Therapeutic factors. Existing research which draws upon sufferers' views about treatment identifies two important factors associated with professional help. The first relates to the timing of intervention. In other words, professional interventions, such as psychotherapy, are perceived to be helpful when made available at the point when the sufferer is ready to begin taking steps towards recovery. The second relates to particular aspects of treatment such as the quality of the therapeutic relationship, being understood by the therapist, being listened to by the therapist and being helped to deal with emotions (Beresin et al, 1989; Hsu et al, 1992; Tozzi et al, 2003).

In the existing literature that explores sufferer's perspectives of recovery, professional and non-professional supports (or Therapeutic and Extratherapeutic factors) are distinguished and discussed separately from each other. By exploring the role (and relative contribution) of psychotherapy in participants' recovery process this study elucidates the interconnectedness between psychotherapy and the changes participants made in their day-to-day lives that facilitated recovery. This identifies, for this group of participants, that some of the psychological changes that take place in recovery happen as a result of the psychotherapeutic work undertaken in therapy. Therefore the interconnection between everyday lived experiences and therapy experiences are more *integrated* as the gains made in therapy are translated into relationships and situations outside.

Participants were offered a range of different psychotherapy experiences, delivered by different professionals, in a range of treatment contexts within Scotland, at different times and for varying durations. This research provides detailed information on the role of both technical and non-technical aspects of psychotherapy spanning support, learning and action factors. It highlights some of the techniques that psychotherapists used during individual therapy and reinforces that for people affected by anorexia, the quality of the therapeutic relationship is the cornerstone of all psychotherapeutic work.

Moreover, my methodological decision to explore personal accounts of recovery and psychotherapy alongside and in relationship with accounts of developing anorexia

allows the potential *significance* of the identified therapeutic factors to be highlighted. In doing so, I find that individual psychotherapy was perceived as helpful precisely when it appeared to address one or more of the three themes linked to the development of anorexia. Without exception, participants' created powerful connections between their difficult life experiences and the development of anorexia. While the 'chain of events' leading up to the eventual diagnosis differed within each individual account, the causal and temporal process of meaning-making indicates that participants' perceived that anorexia *emerged out of* or *helped to mediate* other life difficulties. Attending to and supporting the sufferer with the issues that *they believed* to be significant in developing anorexia directly informed the work undertaken in psychotherapy, including the goals and tasks in therapy, the selection of interventions and the type of relational bond that would support the psychotherapeutic enterprise. Indeed, one of the most striking features of participants' experiential descriptions of psychotherapy was the centrality of the therapeutic relationship with their therapist. I observed the significance of particular kinds of transactions and interactions and understand these to be opportunities to engage in new and different interpersonal and intra-psychic interactions as a way to meet developmental deficits or start to repair earlier interpersonal injuries. As a result, I did not find that any particular model of psychotherapy was articulated by participants as more helpful than another. Rather, the availability of the therapist to attend to the issues which were perceived to be most important to the sufferer is a key finding and this has implications for psychotherapy practice.

Finally, participants' definitions of recovery also seem to be influenced by their beliefs and perceptions about important causal and precipitating factors. Indeed participants' beliefs about whether it was and is ever possible to make a complete recovery were examined within their broader life narratives. This illuminates a significant perception: that anorexia was understood and therefore experienced as a solution for or way of managing other life difficulties.

Reviewed alongside existing studies which seek and explore subjective definitions of recovery (Pettersen and Rosenvinge, 2002; Frederici and Kaplan, 2008), the definitions of recovery from this study not only propose subjective thresholds for recovery but offer a more critical examination of the term 'recovery'. The study by Pettersen and Rosenvinge, (2002) defined recovery through a description of cognitive, affective and

behaviour changes - what recovery might look and feel like. The study by Frederici and Kaplan, (2008) defined recovery by contrasting it alongside descriptions of 'non-recovery'. This study defines recovery as a state that might include the elimination of symptoms, a Destination, or the persistence of them, a Journeying. These subjective definitions of recovery offer the opportunity to get closer to the lived experience of recovery, which for some participants involves the continued management of weight and shape concerns. Therefore recovery is not necessarily synonymous with a more traditional notion of 'cure'.

This study contributes to knowledge production by offering, to the best of my knowledge, the first piece of research that specifically explores the role of psychotherapy in recovery from sufferers' perspectives. Findings from this study indicate that psychotherapy can attend to *meaning-making and symptom reduction*. However, for participants in this study, interventions seem to be carefully timed to match the participant's readiness to change and the management of other important matters impinging on each participant's hierarchy of needs, such as addressing immediate health or safety issues. Underpinning this was the compassionate and respectful quality of the therapeutic alliance and the individual therapist's willingness to explore issues related to the development and/or maintenance of anorexia, without necessarily formulating anorexia as the key problem. I conclude that participants in this study believed that their psychotherapists were prepared to allow the direction of the psychotherapeutic work to be led by the participant's beliefs, understandings, opinions and ideas about anorexia. This research also offers an insight into the ways that sufferers of anorexia directly *attribute meanings* to their illness experience and offers an understanding of subjective thresholds for recovery and the criteria that an individual might draw upon to help inform their personally-defined recovery status. It also illuminates subjectively-created associations between developing anorexia and recovery and the factors that help sufferers with their recovery process.

7.6(2) Implications for psychotherapy practice

Participants' experiential accounts provide a way to access how this group of people made sense of their lived experience of developing anorexia, recovery and psychotherapy. This study highlights that people draw upon a range of ideas to make

sense of complex occurrences, such as an episode of significant mental ill-health. Participants created associations between a range of difficult life experiences they had lived through and developing anorexia. They considered that recovery occurred when they had been able to address or resolve these difficult experiences in some way. They further considered that psychotherapy directly supported them to address or resolve these difficult life experiences. These findings have implications for psychotherapy practice.

The beliefs and perceptions sufferers' create about the development of anorexia have significance and importance. These need to be listened to, validated, reconstructed and reworked to support the process of recovery. Through the exploration of such meanings, sufferers can reflect on the interpretations they have made about their life experiences and begin to consider and experiment with alternative constructions of themselves, others and the world in which they live. These curative tasks may be undertaken within the broader context of sufferers' lives (through extratherapeutic factors) as well as within the interpersonal context of psychotherapy (through therapeutic factors).

Each participant in this study had the opportunity to undergo individual psychotherapy and their ability to make active changes in their day-to-day lives resulted, in part, from the discussion and rehearsal of these changes with their individual therapist. In other words, I conclude that there is a clear connection between therapeutic and extratherapeutic factors, with each having an influential relationship on the other.

In psychotherapeutic work with sufferers of anorexia, it is therefore imperative that the things which are personally meaningful for them are not only valued and respected, but should inform the actual goals and tasks of therapy. Psychotherapy should always allow for meaning-making as part of any overarching objectives to preserve life and reduce physical, behavioural and psychological symptoms. If sufferers' possess powerful meanings about their experience of anorexia, where it 'came from', 'why it happened', 'what needs to change to begin recovery', these issues should occupy a central position in psychotherapeutic work. This conclusion is supported by studies that have explored sufferers' satisfaction with treatment. Sufferers' tend to be most satisfied with the therapeutic alliance with members of their treatment team and less satisfied with treatment elements aimed at coercively restoring physical health (Halvorsen and Heyerdahl, 2007).

This study points to the importance of the way clinicians see sufferers. If we move away from seeing sufferers of anorexia as resistant to change due to the "maddeningly egosyntonic" (Strober, 2004) elements of anorexia and we start from the position of aiming to understand the function and purpose of anorexia in the sufferer's life, then we might see a decrease in apparent resistance to change as the psychotherapeutic enterprise becomes more democratic and responsive.

This brings me to the influence of psychotherapy in influencing change and in particular, shaping and developing the sufferer's autobiographical narrative during the psychotherapeutic process. Participants in this study received a variety of therapeutic approaches, in a range of different contexts. Within their psychotherapy, I believe that each participant and therapist established a psychological formulation for the development of the eating disorder. They explored and identified significant predisposing, precipitating, perpetuating and protective factors, and, in doing so, illuminated important meanings about the purpose of anorexia in the sufferer's life.

In other words, while different therapies favour different methods, findings from this study indicate that the process of therapy (with most psychotherapy modalities) seeks to create causal links by supporting the development of an explanatory account. Personal histories are narrated and reworked into a new format, reframing episodes in time or creating 'chapters' about before, during and after, detailing triggers, maintaining factors and recovery as the story progresses. It is during this process that perceptions and beliefs about developing anorexia can be explored and made sense of and new constructs can be devised and experimented with. I would argue that psychotherapists have a significant degree of influence over their client's narrative accounts, which can lead to change and recovery. As McLeod (1997) suggested:

> The therapist shapes what happens by selective attention and inattention, filtering what is observed through personally held theory. Each therapist has a story to tell about how life should be lived and cannot help but convey this story to clients" (page 23).

Accordingly, perceptions and beliefs are challenged in psychotherapy, making way for new and alternative explanations and meanings, which enables the sufferer to begin to

contemplate change.

McAdam (2003) argued that the stories that we hold about ourselves, our life and our experiences, help shape and inform our self identity, who we perceive we are. Therefore working with personal narratives within therapy, particularly "stories that are 'problem saturated'- where the emphasis is on negative events, failures, dysfunction, helplessness and powerlessness" (Dallos, 1999, page 114) is extremely useful. Being supported to create a coherent narrative about such negative events, affords the teller the opportunity to consider alternative plots and storylines. By altering the narrative, there is the possibility to alter the lived experience of it. As Kelly and Dickinson (1997) suggested, "the narrative self produces and sustains meanings that are intersubjectively shared. Thus the narrative is orderly and so is self" (page 276).

However, I would argue that it is only possible to begin exploring alternative plots and storylines if the sufferer's subjective meanings are given the attention and respect that they deserve. Findings from this study highlight the central importance of the development of a collaborative formulation of the development of anorexia. This should be led by the client/patient's perspectives of what anorexia means to them, to those around them and the life they are living. If undertaken sensitively, so that the recipient of psychotherapy is able to share as much relevant information as possible, this can usefully point towards the kinds of interventions that may be necessary to support recovery. It would appear that this requires different interventions for different people, with a range of understandings and meanings of their eating disorder.

Finally, like many psychotherapy studies (Roth and Fonagy, 2005), this research also indicates that a strong therapeutic relationship is essential to enable positive change. While psychotherapists may use different techniques to address particular difficulties that their client experiences, without a strong psychotherapeutic relationship that is attuned to the client's interpersonal history, remains open and curious about areas of interpersonal strength and deficit and matches therapeutic engagement accordingly, I conclude that such techniques will have limited effect.

7.6(3) Contributions to the field of eating disorder research: Eliciting narratives as a Compassion Technology

> *Why I am afraid to tell you Who I am? Because you might not like Who I am*
> *And it is all I have.*
>
> *(John Powell, 1969).*

Finally, there is a more fundamental and essential value and purpose for the use of phenomenological methodologies in the field of eating disorders research. This is not something I have learned from books, my supervisors or other researchers. The participants in this study have taught me this. Having spent years working with participants' transcripts, reading their narratives, pondering their stories and aiming to make sense of them, one of the most significant aspects of this, is that I have genuinely come to care about what happened and continues to happen to these people. At the start of the study, I was seeking subjects, whom I hoped would allow me access to expert subjective information on illness experience, on recovery and the role that psychotherapy can play in that process. However, as the study progressed, I became less concerned with the units of content (about developing anorexia, recovery, and psychotherapy), and more concerned with their entire stories. As I became more interested in the entire stories, I become much more concerned about the person telling it. Therefore, when the participant *mattered* to me, I was aware of a different motivation to understand their stories as fully as possible and to better understand how psychotherapy can help. This shifted from being based on my need to understand their stories for my own purposes as researcher to a desire to understand their stories because the people telling them are intrinsically important.

In other words, I have engaged emotionally and intellectually in this research process, with my 'heart and mind'. I question: what are the implications for clinicians and researchers if we engage emotionally and intellectually with the sufferers we are charged to help, in this case, sufferers of anorexia?

As discussed in Chapter One, anorexia is a condition associated with a chronic course and sufferers are often under the care of mental health services for many years. Sufferers can reach levels of physical extremis, requiring intensive care and support. In this

context, the helping task requires clinicians to work alongside the sufferer and support them to make important choices about their anorexia. This kind of work cannot be undertaken without a positive therapeutic relationship and in order to be therapeutic, the relationship must contain a benign emotional bond, drawing upon human kindness and compassion. Person-centred care (including the provision of psychotherapy) requires a particular kind of emotional engagement with the sufferer, based on the virtue of compassion. Compassion means *to suffer together with* and involves the emotional aspects of empathy and sympathy. Gilbert (2010) suggested:

> Compassion can be defined in many ways, but its essence is a basic kindness, with a deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it (page xiii).

In my view, the most fundamental and essential value of stories and story telling is based on their capacity to deepen and share awareness of the suffering of ourselves and others. Moreover, our stories are one of the most powerful and effective ways of securing care from the listener(s). If the listener cares about the story, they care about the teller. Therefore, telling stories in our day-to-day life with people we meet, with a psychotherapist, or indeed with a researcher, harnesses the reliable way that storytelling can create an atmosphere of compassion. If technologies are knowledge used in practical ways, then telling stories is a technology of compassion. Within this kind of ethical framework, I am not concerned that people's stories change in relation to context. Indeed, the way a story is told, might reveal the teller's wishes, needs and wants to the listener. These are part of interpersonal and social connectedness and as a result are expressions of being human.

7.7 Limitations of this study

No research is without its limitations and this study is no different. To discuss the limitations of this study, it is important to situate these within a qualitative research paradigm and reflect on them within the terms of quality standards for qualitative studies. As Flyvbjerg (2001) helpfully argued:

> The social sciences are strongest where the natural sciences are weakest; just as the social sciences have not contributed much to explanatory and predictive theory, neither have the natural sciences contributed to the reflexive analysis and discussion of values and interests, which is a prerequisite for any enlightened political, economic, and cultural development in any society (page 3).

There has been robust debate on assessing the quality of qualitative research studies (Sandelowski, 1993; Dixon-Woods et al, 2004; Barbour, 2007). Yardley (2000) proposed four broad principles for assessing quality:

- Sensitivity to context;
- Commitment and rigour;
- Transparency and coherence, and
- Impact and importance.

Smith et al (2009) discussed ways in which such criteria can be fulfilled in IPA studies. I reflect on these principles when considering the particular limitations of my research. I discuss each of the principles in turn, but would stress that they are interconnected and overlap across a range of my methodological choices.

Firstly, I believe I demonstrate sensitivity to context in all stages of the research process. This includes:

- Selecting the focus of investigation - My perception of the need to carry out research which explores sufferers' perspectives of the role of psychotherapy in recovery from anorexia. I would argue that this exemplifies my awareness of the value of subjective experience, coupled with my concern that such experience is frequently excluded or sits on the fringes on mainstream knowledge production. As a result, I selected an interpretative phenomenological methodology to access such lived experience;
- During data collection - By seeking to produce good quality data derived from individual interviews in which participants felt at ease, were sufficiently comfortable to share intimate personal information, and experienced a respectful interaction with me in my role as researcher;

- During data analysis - By my sustained immersion with participants' accounts and the discipline involved in seeking to 'stay close' to their subjective accounts, whilst acknowledging the psychological knowledge I brought to the data analysis process;
- Presenting the research findings – By my continual use of verbatim extracts to support my arguments and to give a voice to my participants and enable the reader to reflect on the transparency, coherence and believability of my findings.

While these methodological choices are consistent with an IPA methodology, they place particular limitations on the study. While phenomenology seeks to uncover meaning, hermeneutics interprets the meanings (Backstrom and Sundin, 2007). The combination of these descriptive and interpretative elements in my selected methodology means that the findings from this study represent inter-subjective understandings (Smith et al, 2009).

IPA is concerned with examining human issues and concerns as they are perceived and represented by individual people. This approach relies on the participant's capacity to have awareness of, and the means to represent, their experiences to others and the researcher's capacity to seek to get close to that lived experience through the interpretative process. This involves a two-stage process through which the researcher tries to interpret the participant's sense-making activity. This 'double-hermeneutic' (Smith et al, 2009) seeks to identify and illustrate superordinate themes. Such themes represent meanings which are necessarily co-constructed.

Within this study, subjective experience is understood as being comprised of the beliefs, perceptions, assumptions, thoughts, feelings and memories of the participants involved. These factors inform the participant's interpretative process as they aimed to make sense of their personal experience of anorexia. However, what each person brings to the process of meaning-making is unique to them and accordingly, their experience of anorexia is essentially idiographic. The interior experience of anorexia may be similar or different between sufferers as they draw upon their own methods of understanding to make sense of it.

Furthermore, it must be acknowledged that participants' accounts are unavoidably filtered through my own fore-structures. As a psychotherapist working in the field of eating disorder treatment, my analysis of the data is by no means as neutral activity. Although I have aimed to maintain an open and curious stance throughout the data analysis process, it is inevitable that I bring my own beliefs, ideas, conceptions and understandings to the data analysis process. It is entirely possible that a different researcher, drawing upon their own fore-structures would interpret the data differently and may or may not produce different findings. Accordingly, the findings from this study can be best understood to represent a co-construction of meanings in a particular context, at a specific time, for a dedicated purpose. As previously stated, they are inter-subjectively bound.

Nonetheless, the process of understanding ourselves and others requires engagement with our biases (Schwandt, 2001). As Garrison (1996) suggested:

> Prejudices are the very kinds of prejudgements necessary to make our way, however tentatively, in everyday life, through conversation, and action. The point is not to free ourselves of all prejudice, but to examine our historically inherited and unreflectively held prejudices and alter those that disable our efforts to understand others and ourselves (page 434).

It is also important to remember that qualitative research is not aimed at establishing facts and while findings can be disagreed with, they can no more be proven to be 'false' as they can be proven to be 'true'.

Given the idiographic nature of my findings, this understandably raises questions about their significance and the extent to which they might connect with the experiences of a broader group of sufferers. IPA is predicated on balancing idiographic detail with commonalities across the research sample. As a result, this particular methodology respects the individual account and perceptions of each participant whilst attempting to balance this with an account of what might be shared across the group of participants and indeed, a broader context.

As a result, it can only be assumed that the experiences of participants in this study *may* share commonalities with a wider audience of sufferers. If accurate, this can usefully

orient clinicians and researchers to some of the issues that are important for sufferers. In addition, the fact that their beliefs and understandings of developing anorexia and recovery may be influenced by their experience of psychotherapy also offers valuable information into some of the potential ways that psychotherapy might influence people's thoughts, feelings and actions in support of purposeful change. Once again, their accounts about the ways that psychotherapy influenced their thoughts, feelings and actions may connect with other sufferers' psychotherapy experiences, but equally may not. Findings from this study by no means claim to have arrived at an 'essence' or something fundamental about the lived experience of anorexia and need to be utilised more cautiously.

Essentially, IPA aims to produce findings which are concerned with theoretical transferability rather than empirical generalisability. Smith et al, (2009) suggested: "In this case, the reader makes links between the claims in the IPA study, their own personal and professional experience, and the claims in the extant literature" (page 51). By offering the reader a detailed, transparent and contextualised analysis of the accounts of participants, this affords the reader the opportunity to "evaluate its transferability to persons in context which are more, or less, similar" (page 51).

Secondly, I believe I demonstrate commitment and rigour in a number of ways:

- Commitment - By my sustained engagement with the participant's and their experiences over the past few years;
- Rigour - By the appropriateness of my sample in which I aimed to recruit a relatively homogenous sample of a sufficiently small size to ensure a deep immersion in the data. Rigour is also evidence by the quality of the individual interviews and the thoroughness of the data analysis.

However, these methodological decisions also place limitations on the study. Focussing on the issue of rigour, I am aware that I decided not to use method triangulation (Shaw, 2001), for example, the use of a data analysis team or multiple forms of data collection such as the use of diaries and interviews or member checking strategies (Creswell, 1994; Babbie and Mouton, 2001), for example, meeting participants after interviews to share my impressions and understandings and further re-negotiate our inter-subjective

understandings. I decided not to use these options as I believe the individual interviews yielded very detailed data and promoted a high level of negotiation throughout. I also wanted to avoid participant fatigue as each participant had at least two meetings with me and some were also involved in the focus group.

The use of a data analysis team may have added rigour to the study. However, it was not possible to co-ordinate this resource within the practical parameters of a part-time, largely self-funded PhD. However, through rigorous supervision, in which my supervisors saw both the original transcripts of all semi-structured interviews and all of my subsequent analysis as described in *3.9(2)*, coupled with regular and repeated use of direct quotes from participants' accounts, I hope to demonstrate that my findings reflect a 'close enough' engagement with each participant's experiential account. This does not afford the level of triangulation or member checking that a research team would, but it ensures that my interpretations and subsequent findings have been scrutinised. Considered in relation to the extant literature described in Chapter Two, I hope to afford the reader the opportunity to assess the credibility, transparency and coherence of my findings in spite of the inherent limitations of my methodological choices.

While a homogenous sample is a requirement of IPA, my sample might in itself leave the study open to critique. This methodology did not provide access to potential participants without this particular kind of self-awareness and communicative desire and required me to access and recruit potential participants who possess both. I therefore recruited a unique sample of people with particular things to say about a number of specific lived experiences. This sample includes people who wanted to talk to a researcher and did so within the context of this study. These are people who had things they wanted to say about developing anorexia, recovery and their experience of psychotherapy. This sample contains people who have recovered from anorexia (according to the EDE) and possess direct experience of individual psychotherapy. As a result, the storied accounts generated by this group of people will inevitably be influenced, to a greater of lesser extent, by the sense-making work they have undertaken during individual therapy. Therefore, this sample cannot be seen to represent a broad range of other people, such as those who might not want to talk to a researcher, those who don't have particular views and ideas about their lived experience of anorexia and recovery, those who have not received psychotherapy to assist in their recovery process,

those who drop out of treatment altogether or indeed those people who recover without any professional interventions.

In addition, the sample size places limitations on my findings. Smith et al (2009) considered that restricted participant numbers permits a richer depth of analysis that a larger sample size would inhibit. However, a smaller and self-selecting sample places restrictions on the light that can be shed on issues affecting a broader audience of sufferers. For example, all participants in this study had achieved recovery from anorexia and all perceived psychological therapy as being useful in aiding recovery. This study does not incorporate the meanings of people who have recovered *without* the use of psychotherapy. The views of people who have received psychotherapy for the treatment of anorexia and not found it to be of use, are also absent. Taking these issues into account, the findings in this study can be understood to offer a 'moment in time' representation of illness and recovery, for a particular group of people. Nonetheless, this 'moment of time' is rich with subjective expertise of anorexia and therefore has much to teach us.

Moreover, as previously mentioned, the aim of this study is not to produce findings that are generalisable. Malim et al (1992) argued that generalisations are largely not feasible and idiographic studies are potentially subjective, intuitive and impressionistic. While broad generalisations may not be possible, Reid et al (2005) suggested that the identification of commonalities across participant accounts and analytic commentary can result in powerful insights which have wider implications. Caldwell (2008) considered that it is not the purpose or remit of IPA to produce 'Theory' with a capital 'T'. Findings can nonetheless influence and contribute to theory in a broader, 'lower case' sense.

As a qualitative study, the purpose of gathering data is to generate and construct theoretical meanings relating to recovery from anorexia and the role of psychotherapy. However, such theoretical meanings are not intended to produce a comprehensive theory relating to the role of psychotherapy in recovery from anorexia. This research seeks to provide partial theoretical meanings based on sufferers' perspectives, and more accurately, the perspectives of the participants in this study.

Thirdly, I believe I demonstrate transparency and coherence in a range of ways:

- Transparency – By how clearly the stages of the research are written up in the study. I aimed to do this in my discussion of important stages of the research process, such as how participants were recruited, the construction of the interview schedule, and the steps taken in data analysis, and
- Coherence - By my presentation of my data analysis and findings.

While I have tried to 'do justice' to the research process, my participants' accounts and my interpretation of them, there are inevitably gaps in the process of data collection, analysis and presentation of my findings. One of the gaps relate to the notion that psychotherapy continues to work beyond the point of termination of sessions. As Tait (cited in Kirkwood, 2012) argued, "The benefits of psychotherapy may not be realised at the time – seeds may be sown, they germinate in therapy, but may not flower until the conditions allow" (page 95).

Although all of the participants in this study defined themselves to be recovered, their accounts reflect their views and beliefs at a particular moment in time, as well as within a particular context. As a result, I find myself questioning – might those participants who define recovery as a Journeying eventually reach the Destination of a more complete sense of recovery? Moreover, might those participants who define recovery as a Destination find themselves back on a Journeying process if anorexia returns? In terms of the role of psychotherapy in their recovery process, I also wonder if participants' understandings of that will change over time, if conditions allow the seeds of therapy to eventually flower or to flower again.

As a result, my findings can only be seen to represent a snapshot - a moment in time and accordingly, the coherence of my findings are best judged by the extent to which they remain faithful to my participants' accounts and resonate with readers so they are able to identify with the experiences being described (Giles, 2002).

Another gap relates to the role of language and eloquence. This refers to the gap between my participants' lived experiences and their later descriptions of them and my lived experience of being a researcher and my written description provided in this

thesis. All stories, including the story told in this thesis are necessarily constrained by the limitations of language. My view is that language has the capacity to both describe *and* construct reality and the same event can be described in different ways, in a range of contexts using many different words.

I believe that my findings represent constructs about other people's experience, based on particular types of descriptions which were generated within a research context. However, Willig (2001) argued that an interview narrative says more about the eloquence of the participant than about the experience they describe. She also questioned participants' ability to use language in a way that captures the subtleties and nuances of their personal experiences.

This critique could equally be made about me in my role as researcher. The quality of my research is partly based on the extent to which I can articulate a plausible research account – the extent to which I can tell a compelling story to the reader. Nonetheless, I support Larkin's (2008) suggestion that IPA does not claim to directly access another person's experience but does allow access to an account of their experience, as described by them. I also agree with Lemon and Taylor (1997) who claimed that a phenomenological approach provides a perspective that cannot be achieved through other means and, as such, this is a useful framework for seeking to understand experience. What I have tried to sustain is frequent verbatim extracts from participants' accounts and transparency about the influences on my interpretative process, to allow the reader to gauge the extent to which they agree or disagree, believe or challenge, the finding I present.

Finally, I believe this study provides findings which have impact and importance. To the best of my knowledge this is the first study which seeks to explore sufferers' perspectives of the role of psychotherapy in recovery from anorexia nervosa. This study gives a voice to people who have personal experience of developing anorexia, recovery and the role of psychotherapy in their recovery process. In a clinical and academic backdrop characterised by differing and often opposing views on each of these areas of investigation, this study offers an opportunity to hear directly from people who possess lived experience and in doing so, tells us things that are interesting, useful and ethically important.

7.8 Recommendations for future research

This study raises a number of issues that could be explored through future research. The possible relationship between illness and recovery experience and in particular the idea that recovery seems to stem from attention to the difficulties that contributed to the development of anorexia is an important issue to examine further. Given the aims, objectives and methodology deployed in this study, I have concluded that this reflects the ways in which people attribute meaning to complex life experiences. However, this area for investigation could be taken forward by another study which specifically focuses on subjective understandings of causation in anorexia and recovery. Such a study has the potential to further understandings of the psychosocial factors that are important in the development and recovery from anorexia. This could potentially be explored using a mixed methodology including both a qualitative component which would allow examination of subjective accounts of causation and recovery and a quantitative component to recruit a larger sample size and explore findings over a sizeable group of sufferers.

This study also looked at a range of psychotherapy approaches and it would be helpful to explore the content and process of psychotherapy in more detail to gather further information on the meaning-making versus symptom reduction positions to psychological treatment. If the findings from this study suggest that useful psychotherapy addresses both, this points to the need for clinicians to match psychotherapy interventions more skilfully to their client's subjective accounts and with a greater understanding of what works for whom and when. This area for investigation could potentially be taken forward by another study which examines both the context and process of psychotherapeutic work in a very detailed way, for example by selecting a methodology that would allow session by session detail to be gathered and a micro-analysis of psychotherapeutic interventions and transaction.

Finally and speaking more generally, I recommend and hope that this study be followed by an increase in qualitative research which draws upon subjective understandings of the lived experience of anorexia. Situated alongside research which aims to achieve

explanatory findings and comes from a more positivist perspective, it may be possible to begin to establish inter-disciplinary dialogues, meaning that the voices of people who have lived with anorexia have a seat at the table of knowledge production.

Bibliography

Ainsworth, A. M. (1979). "Infant–mother attachment." *American Psychologist* **34**: 932-937.

Alexander-Mott, L. and D. B. Lumsden (1994). *Understanding eating disorders: Anorexia nervosa, bulimia nervosa, and obesity*. Washington, D.C., Taylor & Francis.

Allot, P., L. Loganathan, et al. (2002). "Discovering hope for recovery: A review of a selection of recovery literature, implications for practice and systems for change." *Canadian Journal of Community Mental Health* **21**(3): 1-22.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders : DSM-IV-TR*. Washington, DC, American Psychiatric Association.

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders*. Washington, D.C., American Psychiatric Association.

Ametller, L., J. Castro, et al. (2005). "Readiness to recover in adolescent anorexia nervosa: Prediction of hospital admission." *Journal of Child Psychology and Psychiatry* **46**(4): 394-400.

Amini, F., T. Lewis, et al. (1996). "Affect, attachment, memory: Contributions toward psychobiologic integration." *Psychiatry* **59**(3): 213-39.

Andrews, B. (1997). "Bodily shame in relation to abuse in childhood and bulimia: A preliminary investigation." *British Journal of Clinical Psychology* **36**(1): 41-49.

Anthony, W. A. (2007). *Toward a vision of recovery: For mental health and psychiatric rehabilitation services*. Boston, MA, Center for Psychiatric Rehabilitation, Boston University.

Arkowitz, H. (1989). "The role of psychotherapy integration." *Journal of Integrative and Eclectic Psychotherapy* **8**(1): 8-16.

Armstrong, J. G. and D. M. Roth (1989). "Attachment and separation difficulties in eating disorders: A preliminary investigation." *The International Journal of Eating Disorders* **8**(2): 141-155.

Arroll, M. and V. Senior (2008). "Individuals' experience of chronic fatigue syndrome/myalgic encephalomyelitis: An interpretative phenomenological analysis." *Psychology and Health* **23**(4): 443-458.

Ashworth, P.D. (2003). (Guest editor, special issue). Contingencies of the lifeworld: Phenomenological psychology from Sheffield, England. *Journal of Phenomenological Psychology, 34* (2).

Atkinson, P. and D. Silverman (1997). "Kundera's immortality: The interview society and the invention of the self." *Qualitative Inquiry* **3**(3): 304-325.

Babbie, E.R and Mouton, J. (2001). *The practice of social research.* South Africa, Oxford University Press.

Bachner-Melman, R., A. H. Zohar, et al. (2006). "An examination of cognitive versus behavioral components of recovery from anorexia nervosa." *The Journal of Nervous and Mental Disease* **194**(9): 697-703.

Backstrom, B. and Sundin, K. (2007). Feature: "The meaning of being a middle-aged close relative of a person who has suffered a stroke, 1 month after discharge from a rehabilitation clinic". *Nursing Inquiry* **14**(3): 243-254.

Bailer, U. F., Frank, G.K, et al. (2005). "Altered brain serotonin 5-HT1A receptor binding after recovery from anorexia nervosa measured by positron emission tomography and [carbonyl11C]WAY-100635." *Archives of General Psychiatry* **62**(9): 1032-41.

Bailey, P. H. and S. Tilley (2002). "Storytelling and the interpretation of meaning in qualitative research." *Journal of Advanced Nursing* **38**(6): 574-83.

Baker, S., S. Strong, et al. (2001). *Roads to recovery: How people with mental health problems recover and find ways of coping*. London, Mind.

Bamford, B. and E. Halliwell (2009). "Investigating the role of attachment in social comparison theories of eating disorders within a non-clinical female population." *European Eating Disorders Review* **17**(5): 371-379.

Bandolier,(1994)."Bandolier:evidencebasehealthcare. "www.medicine.ox.ac.uk/bandolier.

Barbour, R. (2007). *Doing focus groups.* Los Angeles, Sage Publications.

Barbour, R. S. (2007). *Introducing qualitative research: a student's guide to the craft of doing qualitative research*. London, Sage

Bardone-Cone, A. M., M. B. Harney, et al. "Defining recovery from an eating disorder: Conceptualization, validation, and examination of psychosocial functioning and psychiatric comorbidity." *Behaviour Research and Therapy* **48**(3): 194-202.

Barker, P. (2001). "The tidal model: Developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing." *Journal of Psychiatric & Mental Health Nursing* **8**(3): 233-240.

Bar-Levav, R. (1988). *Thinking in the shadow of feelings: A new understanding of the hidden forces that shape individuals and societies*. New York, Simon and Schuster.

Bashan,K.and Miehls,D (2004). *Transforming the legacy: Couple therapy with survivors of childhood trauma.* New York: Columbia University Press.

Becker, A. (2004). "Television, disordered eating, and young women in Fiji: Negotiating body image and identity during rapid social change." *Culture, Medicine and Psychiatry* **28**(4): 533-559.

Becker, A. E., R. A. Burwell, et al. (2002). "Eating behaviours and attitudes following prolonged exposure to television among ethnic Fijian adolescent girls." *The British Journal of Psychiatry* **180**: 509-14.

Bell, M. S. (2000). *Narrative design: Working with imagination, craft, and form*. New York, W.W. Norton & Co.

Bentall, R. P. (2003). *Madness explained: Psychosis and human nature*. London, Allen Lane.

Beresin, E. V., C. Gordon, et al. (1989). "The process of recovering from anorexia nervosa." *The Journal of the American Academy of Psychoanalysis* **17**(1): 103-30.

Bergin, A. E. and M. J. Lambert (1978). The evaluation of outcomes in psychotherapy. *Handbook of psychotherapy and behaviour change: Am empirical analysis*. S. L. Garfield and A. E. Bergin. New York, Wiley**:** 139-189.

Blowers, L. C., N. J. Loxton, et al. (2003). "The relationship between sociocultural pressure to be thin and body dissatisfaction in preadolescent girls." *Eating Behaviours* **4**(3): 229-244.

Blumenfeld-Jones, D. (1995). "Fidelity as a criterion for practicing and evaluating narrative inquiry." *International Journal of Qualitative Studies in Education : QSE.* **8**(1): 25.

Bordin, E. S. (1979). "The generalizability of the psychoanalytic concept of the working alliance." *Psychotherapy: Theory, Research & Practice* **16**(3): 252-260.

Bowlby, J. (1958). "The nature of the child's tie to his mother." *International Journal of Psychoanalysis* **39**(5): 350–73.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York, Basic Books.

Brown, C. and K. Jasper (1993). *Consuming passions: Feminist approaches to weight preoccupation and eating disorders*. Toronto, Ont., Second Story Press.

Brown, G. W. and T. Harris (1978). "Social origins of depression: A reply." *Psychological Medicine* **8**(04): 577-588.

Brown, W., N. Kandirikirira, et al. (2006). *Recovering mental health in Scotland: Report on narrative investigation of mental health recovery*. Glasgow, Scottish Recovery Network.

Bruch, H. "Hunger and instinct." *Journal of Nervous and Mental Disease* **149**(2): 91-114.

Bruch, H. (1974). "Perils of behavior modification in treatment of Anorexia Nervosa." *JAMA: The Journal of the American Medical Association* **230**(10): 1419-1422.

Bruch, H. (1978). "Obesity and anorexia nervosa." *Psychosomatics* **19**(4): 208-12.

Bruch, H. (1985). *Four decades of eating disorders - Handbook of psychotherapy for anorexia* New York, Guilford Press.

Bruner, J. S. (1990). Acts of meaning. Cambridge, Mass., Harvard University Press

Bryant-Waugh, R. and B. Lask (2002). *Anorexia nervosa and related eating disorders in childhood and adolescence*. Hove, East Sussex, Brunner-Routledge.

Bulik, C. M., N. D. Berkman, et al. (2007). "Anorexia nervosa treatment: A systematic review of randomized controlled trials." *The International Journal of Eating Disorders* **40**(4): 310-320.

Bulik, C. M., P. F. Sullivan, et al. (2000). "Outcome of anorexia nervosa: Eating attitudes, personality, and parental bonding." *The International Journal of Eating Disorders* **28**(2): 139-47.

Bulik, C. M., P. F. Sullivan, et al. (2000). "Twin studies of eating disorders: A review." *The International Journal of Eating Disorders* **27**(1): 1-20.

Burton, A. (1971). *Interpersonal psychotherapy*. Englewood Cliffs, N.J., Prentice-Hall.

Bury, M. (2001). "Illness narratives: Fact or fiction?" *Sociology of Health and Illness* **23**(3): 263-285.

Byng-Hall, J. (1995). *Rewriting family scripts: Improvisation and systems change*. New York, Guilford Press.

Campbell, J. D., P. D. Trapnell, et al. (1996). "Self-concept clarity: Measurement, personality correlates, and cultural boundaries." *Journal of Personality and Social Psychology*. **70**(1): 141.

Candelori, C. and A. Ciocca (1998). Attachment and eating disorders. In P.Bria, A.Ciocca and S.Risio (Eds.), *Psychotherapeutic issues on eating disorders: Models, methods, and results.* Rome, Italy, Società Editrice UniversoBria**:** 139-153.

Carradice, A., M. C. Shankland, et al. (2002). "A qualitative study of the theoretical models used by UK mental health nurses to guide their assessments with family caregivers of people with dementia." *International Journal of Nursing Studies* **39**(1): 17-26.

Carter, J. C., C. Bewell, et al. (2006). "The impact of childhood sexual abuse in anorexia nervosa." *Child Abuse & Neglect* **30**(3): 257-269.

Carter, J. C., E. Blackmore, et al. (2004). "Relapse in anorexia nervosa: A survival analysis." *Psychological Medicine* **34**(4): 671-679.

Cassell, E. J. (1985). *Talking with patients*. Cambridge, Mass., MIT Press.

Cassell, E.J and Siegler, M (1985). *Changing values in medicine*, Frederick, Md., University Publications of America.

Catherall, D. R. (1992). *Back from the brink: A family guide to overcoming traumatic stress*. New York, Bantam Books.

Cattarin, J. A., J. K. Thompson, et al. (2000). "Body image, mood, and televised images of attractiveness: The role of social comparison." *Journal of Social and Clinical Psychology* **19**(2): 220-239.

Chamberlayne, P., J. Bornat, et al. (2000). *The turn to biographical methods in social science: Comparative issues and examples*. London; New York, Routledge.

Channon, S., P. de Silva, et al. (1989). "A controlled trial of cognitive-behavioural and behavioural treatment of anorexia nervosa." *Behaviour Research and Therapy* **27**(5): 529-35.

Channon, S. and W. P. DeSilva (1985). "Psychological correlates of weight gain in patients with anorexia nervosa." *Journal of Psychiatric Research* **19**(2-3): 267-271.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage Publications.

Charon, R. and M. Montello (2002). *Stories matter: The role of narrative in medical ethics*. New York, Routledge.

Chassler, L. (1997). "Understanding Anorexia Nervosa and Bulimia Nervosa from an attachment perspective." *Clinical Social Work Journal* **25**(4): 407-423.

Chernin, K. (1985). *The Hungry Self: Women, eating and identity* New York, Times Books.

Churchill, S. and Bayne, R. (1998). "Psychological type and conceptions of empathy in experienced counsellors." *Counselling Psychology Quarterly* **11**(4): 379-390

Cicourel, A. V. (1964). *Method and Measurement in Sociology*. New York, Free Press of Glencoe.

Clark, J. A. and E. G. Mishler (1992). "Attending to patients' stories: Reframing the clinical task." *Sociology of Health & Illness* **14**(3): 344-372.

Clarke, H., A. Rees, et al. (2004). "The big idea: Clients' perspectives of change processes in cognitive therapy." *Psychology and Psychotherapy: Theory, Research and Practice* **77**(1): 67-89.

Clark-Keefe and Kelly (2009). "Between antagonism and surrender: Using art to dwell more resolutely in irresolution." *Creative Approaches to Research* **2**(1): 22-38.

Clarkson, P. (1990). "A multiplicity of psychotherapeutic relationships." *British Journal of Psychotherapy* **7**(2): 148-163.

Clarkson, P. (1996). "Researching the therapeutic relationship in psychoanalysis, counselling psychology and psychotherapy - a qualitative inquiry." *Counselling Psychology Quarterly* **9**(2): 143-162.

Clinton, D., C. B. Thorn, et al. (2004). "Patient satisfaction with treatment in eating disorders: Cause for complacency or concern?" *European Eating Disorders Review* **12**(4): 240-246.

Clinton, D. N. (1996). "Why do eating disorder patients drop out?" *Psychotherapy and Psychsomatics* **65**(1): 29-35.

Coates, J. (1996). *Women talk: Conversation between women friends*. Oxford: Blackwell Publishers.

Cockell, S. J., J. Geller, et al. (2002). "The development of a decisional balance scale for Anorexia Nervosa." *European Eating Disorders Review* **10**: 359-375.

Cockell, S. J., S. L. Zaitsoff, et al. (2004). "Maintaining change following eating disorder treatment." *Professional Psychology Research and Practice* **35**: 527-534.

Cohler, B. J. (1982). *Personal narratives and life course: Life span development and behaviour*. New York, Academic Press.

Cole-Detke, H. and R. Kobak (1996). "Attachment processes in eating disorder and depression." *Journal of Consulting and Clinical Psychology* **64**(2): 282-290.

Collier, D. A. and J. L. Treasure (2004). "The aetiology of eating disorders." *The British Journal of Psychiatry* **185**(5): 363-365.

Collins, P. (1998). "Negotiating selves: Reflections on 'unstructured' interviewing." *Sociological Research Online* **3**(3).

Connan, F., I. C. Campbell, et al. (2003). "A neurodevelopmental model for anorexia nervosa." *Physiology & Behavior* **79**(1): 13-24.

Cook-Darzens, S., C. Doyen, et al. (2005). "Self-perceived family functioning in 40 French families of anorexic adolescents: Implications for therapy." *European Eating Disorders Review* **13**(4): 223-236.

Cooper, Z. and C. Fairburn (1987). "The eating disorder examination: A semi-structured interview for the assessment of the specific psychopathology of eating disorders." *The International Journal of Eating Disorders* **6**(1): 1-8.

Corbin, J. and J. M. Morse (2003). "The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive topics." *Qualitative Inquiry* **9**(3): 335-354.

Couturier, J. and J. Lock (2006). "What is remission in adolescent anorexia nervosa? A review of various conceptualizations and quantitative analysis." *The International Journal of Eating Disorders* **39**(3): 175-83.

Coyle, A. and Rafalin, D. (2001). "Jewish gay men's accounts of negotiating cultural, religious, and sexual identity: A qualitative study." *Sage Family Studies Abstracts* **23**(4): 411-568.

Cozolino, L. J. (2002). *The neuroscience of psychotherapy: Building and rebuilding the human brain*. New York, Norton.

Cozolino, L. J. (2006). *The neuroscience of human relationships: Attachment and the developing social brain*. New York, Norton.

Creswell, J.W. (1994). *Research design: qualitative & quantitative approaches.* Thousand Oaks, Calif., Sage Publications

Crisp, A. H. (1970b). "Anorexia Nervosa: "Feeding disorder, nervous malnutrition" or weight phobia?" *World Review of Nutrition and Dietetics* (12.).

Crisp, A. H. (1977). "Diagnosis and outcome of Anorexia Nervosa" *Proceedings of the Royal Society of Medicine* **70**: 464–470.

Crisp, A. H. (1979). "Anorexia nervosa: A disease of our time. (The need to make provision for it)." *Health and Hygiene* **2**(3).

Crisp, A. H. (1980). *Anorexia Nervosa: Let Me Be*. New York, Grune & Stratton.

Crisp, A. H., J. S. Callender, et al. (1992). "Long-term mortality in anorexia nervosa. A 20-year follow-up of the St George's and Aberdeen cohorts." *The British Journal of Psychiatry* **161**(1): 104-7.

Crisp, A. H., B. Harding, et al. (1974). "Anorexia nervosa. Psychoneurotic characteristics of parents: Relationship to prognosis: A quantitative study." *Journal of Psychosomatic Research* **18**: 167–173.

Crow, S. J., W. Stewart Agras, et al. (2002). "Full syndromal versus subthreshold anorexia nervosa, bulimia nervosa, and binge eating disorder: A multicenter study." *The International Journal of Eating Disorders* **32**(3): 309-18.

D' Abundo, M. and P. Chally (2004). "Struggling with recovery: Participant perspectives on battling an eating disorder." *Qualitative Health Research* **14**(8): 1094-1106.

DaCosta, M. and K. A. Halmi (1992). "Classifications of anorexia nervosa: Question of subtypes." *The International Journal of Eating Disorders* **11**(4): 305-313.

Dahlberg, K., H. Dahlberg, et al. (2008). *Reflective lifeworld research.* Lund, Student litteratur AB.

Dale, A., R. B. Davies, et al.(1994) *Analyzing social and political change: A casebook of methods,* London: Sage Publications.

Dales, S. and P. Jerry (2008). "Attachment, affect regulation and mutual synchrony in adult psychotherapy." *American Journal of Psychotherapy* **62**(3): 283-312.

Dallos, R. (1994). *Social problems and the family*. London, Sage.

Daniel, E., G. Kent, et al. (2005). "Trying to do my best as a mother: Decision-making in families of children undergoing elective surgical treatment for short stature." *British Journal of Health Psychology* **10**(1): 101-114.

Darcy, A. M., K. K. Fitzpatrick, et al. (2010) "All better? How former anorexia nervosa patients define recovery and engaged in treatment". *European Eating Disorders Review* **18**(4): 260-270.

Davidson, L. (2003). *Living outside mental illness: qualitative studies of recovery in schizophrenia.* New York, New York University Press.

Davis, C. and M. A. Katzman (1998). "Chinese men and women in the United States and Hong Kong: Body and self-esteem ratings as a prelude to dieting and exercise." *The International Journal of Eating Disorders* **23**(1): 99-102.

Davison, K. K., C. N. Markey, et al. (2000). "Etiology of body dissatisfaction and weight concerns among 5-year-old girls." *Appetite* **35**(2): 143-151.

De la Rie,S.,et al. (2006). "Evaluating the treatment of eating disorders from the patient's perspective." *The International Journal of Eating Disorders* **39**(8): 667-76.

Deegan, P. E. (1988). "Recovery: The lived experience of rehabilitation." *Psychosocial Rehabilitation Journal* **11**(4): 11-19.

Del Vecchio Good, M.-J., T. Munakata, et al. (1994). "Oncology and narrative time." *Social Science & Medicine* **38**(6): 855-862.

Del Vecchio Good, M.-J., N. M. Gadmer, et al. (2004). "Narrative nuances on good and bad deaths: Tales from high-technology work places." *Social Science & Medicine* **58**(5): 939-953.

Dench, S., R. Iphofen, et al. (2004). *An EU code of ethics for socio-economic research*. Brighton, Institute for Employment Studies.

Denzin, N. K. and Y. S. Lincoln (1998). *Collecting and interpreting qualitative materials*. Thousand Oaks, Calif., Sage Publications.

Department of Health, (1999). *National Service Framework for Mental Health.* London: Department of Health.

Derenne, J. L. and E. V. Beresin (2006). "Body image, media, and eating disorders." *Academic psychiatry: The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry* **30**(3).

Deter, H. C. and W. Herzog (1994). "Anorexia nervosa in a long-term perspective: Results of the Heidelberg-Mannheim Study." *Psychosomatic medicine* **56**(1).

Devitt, M. and K. Sterelny (1987). *Language and reality: An introduction to the philosophy of language*. Cambridge, Mass., MIT Press.

Dittmar, H. (2005). "Introduction to the special issue: Body image vulnerability factors and processes linking sociocultural pressures and body dissatisfaction." *Journal of Social and Clinical Psychology* **24**(8): 1081-1087.

Dittmar, H. and S. Howard (2004). "Thin-ideal internalization and social comparison tendency as moderators of media models' impact on women's body-focused anxiety." *Journal of Social and Clinical Psychology* **23**(6): 768.

Dixon-Woods, M., R. L. Shaw, et al. (2004). "The problem of appraising qualitative research." *Quality & safety in health care* **13**(3): 223-5

Donabedian, A. (1980). *The definition of quality and approaches to its assessment*. Ann Arbor, Mich., Health Administration Press.

Donabedian, A. (1980). *Explorations in quality assessment and monitoring*. Ann Arbor, Mich., Health Administration Press.

Duncan, B. L. and S. D. Miller (2000). *The Heroic Client: Doing client-directed, outcome-informed therapy*. San Francisco, Jossey-Bass.

Dunniece, U. and E. Slevin (2000). "Nurses' experiences of being present with a patient receiving a diagnosis of cancer." *Journal of Advanced Nursing* **32**(3): 611-8.

Duquette, P. (2010) "Reality matters: Attachment, the real relationship, and change in psychotherapy." *American Journal of Psychotherapy* **64**(2): 127-51.

Eckert, E. D., K. A. Halmi, et al. (1995). "Ten-year follow-up of anorexia nervosa: Clinical course and outcome." *Psychological Medicine* **25**(01): 143-156.

Eisenberg, L. and A. Kleinman (1981). *The Relevance of social science for medicine*. Dordrecht; Boston; Hingham, MA, D. Reidel Publishers.

Elliott, J. (2005). *Using narrative in social research: Qualitative and quantitative approaches*. London; Thousand Oaks, SAGE.

Elliott, R. and E. James (1989). "Varieties of client experience in psychotherapy: An analysis of the literature." *Clinical Psychology Review* **9**(4): 443-467.

Engeln-Maddox, R. (2005). "Cognitive responses to idealized media images of women: The relationship of social comparison and critical processing to body image disturbance in college women." *Journal of Social and Clinical Psychology* **24**(8): 1114-1138.

Erikson, E. H. (1963). *Childhood and society. 2d ed.*New York, Norton. Eurich, T. L. and Z. S. Byrne (2004). A closer look at social comparison orientation. *19th the annual conference of the Society for Industrial and Organizational Psychology*. Chicago, Illinois.

Fairburn, C. G. (2008). "Eating disorders: The transdiagnostic view and the cognitive behavioral theory." *Cognitive behavior therapy and eating disorders*: 7-22.

Fairburn, C. G. and K. D. Brownell (2002). *Eating disorders and obesity: A comprehensive handbook*. New York, Guilford Press.

Fairburn, C. G., Z. Cooper, et al. (2003). "Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment." *Behaviour Research and Therapy* **41**(5): 509-28.

Fairburn, C. G., R. Shafran, et al. (1999). "A cognitive behavioural theory of anorexia nervosa." *Behaviour Research and Therapy* **37**(1): 1-13.

Farrington, A., G. Waller, et al. (2002). "Dissociation in adolescent girls with Anorexia: Relationship to comorbid psychopathology." *The Journal of Nervous and Mental Disease* **190**(11): 746-751.

Federici, A. and A. S. Kaplan (2008). "The patient's account of relapse and recovery in anorexia nervosa: A qualitative study." *European Eating Disorders Review* **16**(1): 1-10.

Fenwick, S. (1880). *On the Atrophy of the Stomach and on the Nervous Affections of the Digestive Organs.* London., Churchill.

Festinger, L. (1954). *A theory of social comparison processes.* Indianapolis, Bobbs-Merrill.

Fichter, M. M., N. Quadflieg, et al. (2003). "Predicting the outcome of eating disorders using structural equation modeling." *The International Journal of Eating Disorders* **34**(3): 292-313.

Field, A. E., D. B. Herzog, et al. (1997). "Distinguishing recovery from remission in a cohort of bulimic women: How should asymptomatic periods be described?" *Journal of Clinical Epidemiology* **50** (12): 1339-1345.

Finfgeld, D. (2002). "Anorexia nervosa: Analysis of long-term outcomes and clinical implications." *Archives of Psychiatric Nursing* **16**(4): 176-186.

Flaskas, C. (2007). "Holding hope and hopelessness: Therapeutic engagements with the balance of hope." *Journal of Family Therapy* **29**(3): 186-202.

Flowers, P., C. L. Knussen, et al. (2001). "Re-appraising HIV testing among Scottish gay men: The impact of new HIV treatments." *Journal of Health Psychology* **6**(6): 665-678.

Flyvbjerg, B. (2001). *Making social science matter: why social inquiry fails and how it can succeed again.* Oxford, UK; New York, Cambridge University Press.

Fonagy, P. (2002). *Affect regulation, mentalization, and the development of the self.* New York, Other Press.

Fontana, A. and J. H. Frey (2010) *Interviewing: The Art of Science*.

Foster, J. and A. Murphy (2005). *Psychological therapies in primary care: Setting up a managed service*. London; New York, Karnac.

Frank, A. W. (1995). *The wounded storyteller: Body, illness, and ethics.* Chicago, University of Chicago Press.

Freud, S. (1920). *A general introduction to psychoanalysis.* New York, Boni and Liveright.

Freud, S. (1960). *The psychopathology of everyday life*. London, Hogarth Press and the Institute of Psycho-analysis.

Freud, S. and A. A. Brill (1914). *Psychopathology of everyday life*. New York, Macmillan Co.

Frey, J. H. and A. Fontana (1991). "The group interview in social research." *The Social Science Journal* **28**(2): 175-187.

Frid, I., J. Öhlén, et al. (2000). "On the use of narratives in nursing research." *Journal of Advanced Nursing* **32**(3): 695-703.

Friedberg, N. L. and W. J. Lyddon (1996). "Self-other working models and eating disorders." *Journal of Cognitive Psychotherapy* **10**(3): 193-202.

Gabbard, G. O. (1990). *Psychodynamic psychiatry in clinical practice*. Washington, DC, American Psychiatric Press.

Gadamer, H.-G. (1990). *Truth and method*. New York, Crossroad.

Garner, D. M., et al. (1993). "Anorexia nervosa "restricters" who purge: Implications for subtyping anorexia nervosa." *The International Journal of Eating Disorders* **13**(2): 171-85.

Garrison, J. (1996). "Dewey, Qualitative thought, and context." *International journal of qualitative studies in education: QSE*. **9**(4): 391.

Gatward, N. (2007). "Anorexia nervosa: An evolutionary puzzle." *European Eating Disorders Review* **15**(1): 1-12.

Geddes, J., S. Reynolds, et al. (1998). "Evidence-based practice in mental health." *Evidence Based Mental Health* **1**(1): 4-5.

Gee, J. P. (1985). "The narrativization of experience in the oral style." *Journal of Education* **167**(1): 9-35.

Geller, J. (2002). "Estimating readiness for change in anorexia nervosa: Comparing clients, clinicians, and research assessors." *The International Journal of Eating Disorders* **31**(3): 251-260.

Geller, J., S. J. Cockell, et al. (2001). "Assessing readiness for change in the eating disorders: The psychometric properties of the readiness and motivation interview." *Psychological Assessment* **13**(2): 189-98.

Gelso, C. J. (2009). "The real relationship in a postmodern world: theoretical and empirical explorations." *Psychotherapy research: Journal of the Society for Psychotherapy Research* **19**(3): 253-64.

Gelso, C. J. and J. A. Carter (1985). "The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents." *Counseling Psychologist* **13**(2): 155-94.

Gelso, C. J. and J. A. Hayes (1998). *The psychotherapy relationship: Theory, research, and practice*. New York, Wiley.

Gilbert, P. *Compassion focused therapy: Distinctive features*. London; New York, Routledge.

Giles. D. C. (2002). *Advanced research methods in psychology.* London, Taylor & Francis Books Ltd.

Giorgi, A. (1997). "The Theory, Practice, and Evaluation of the Phenomenological Method as a Qualitative Research Procedure." *Journal of Phenomenological Psychology* **28**(2): 235-260

Glaser, B. G. and A. L. Strauss (1967). *The discovery of grounded theory; Strategies for qualitative research*. Chicago, Aldine Pub. Co.

Goffman, E. (1968). *Asylums: Essays on the social situation of mental patients and other inmates* New York, Peregrine books

Golomb, C. (2002). *Child art in context: A cultural and comparative perspective*. Washington, DC, American Psychological Association.

Gordon, D. A., K. Graves, et al. (1995). "Effect of functional family therapy for delinquents on adult criminal behavior." *Criminal Justice and Behavior* **22**(1): 60-73.

Goss, S. and D. Mearns (1997). "A call for a pluralist epistemological understanding in the assessment and evaluation of counselling." *British Journal of Guidance and Counselling* **25**(2): 189-198.

Gowers, S., K. Norton, et al. (1994). "Outcome of outpatient psychotherapy in a random allocation treatment study of anorexia nervosa." *The International Journal of Eating Disorders* **15**(2): 165-77.

Gowers, S. G., A. Clark, et al. (2007). "Clinical effectiveness of treatments for anorexia nervosa in adolescents: Randomised controlled trial." *The British Journal of Psychiatry* **191**: 427-35.

Grabe, S., J. S. Hyde, et al. (2008). "The role of the media in body image concerns among women: A meta-analysis of experimental and correlational studies." *Psychological Bulletin* **134**(3): 460-476.

Greenspan, M. (1983). *A new approach to women & therapy*. New York, McGraw-Hill.

Greenwood, D., P. Pietromonaco, et al. (2008). "Young women's attachment style and interpersonal engagement with female TV stars." *Journal of Social and Personal Relationships* **25**(3): 387-407.

Grencavage, L. M. and J. C. Norcross (1990). "Where are the commonalities among the therapeutic common factors?" *Professional Psychology: Research and Practice* **21**(5): 372-378.

Griffiths, S. and J. Wallace (1998). *Consuming passions: Food in the age of anxiety.* Manchester; Manchester University Press.

Grigsby, J. and D. Stevens (2000). *Neurodynamics of personality*. New York, Guilford Press.

Groesz, L. M., M. P. Levine, et al. (2002). "The effect of experimental presentation of thin media images on body satisfaction: A meta-analytic review." *The International Journal of Eating Disorders* **31**(1): 1-16.

Guba, E. G. (1978). *Toward a methodology of naturalistic inquiry in educational evaluation*. Los Angeles, Center for the Study of Evaluation, UCLA Graduate School of Education, University of California.

Gubrium, J. F. and J. A. Holstein (1997). *The new language of qualitative method*. New York, Oxford University Press.

Halling, S. (2008). *Intimacy, transcendence, and psychology: Closeness and openness in everyday life*. New York, Palgrave Macmillan.

Halstead, R. W., D. K. Brooks, et al. (1990). "Counsellor and client perceptions of the working alliance." *Journal of Mental Health Counselling* **12(**2): 208-221.

Halvorsen, I. and S. Heyerdahl (2007). "Treatment perception in adolescent onset anorexia nervosa: Retrospective views of patients and parents." *The International Journal of Eating Disorders* **40**(7): 629-639.

Hannan, M. T., N. B. Tuma, et al. (1979). *Income and independence effects on marital dissolution : results from the first three years of SIME/DIME*. Menlo Park, Calif., SRI International.

Hayes, N. (1997). *Doing qualitative analysis in psychology*. Hove, East Sussex, Psychology Press.

Harper, K., N. L. Richter, et al. (2009). "Group work with female survivors of childhood sexual abuse: Evidence of poorer outcomes among those with eating disorders." *Eating Behaviors* **10**(1): 45-48.

Harré, R. and E. H. Madden (1979). *Causal power: A theory of natural necessity*. Oxford, Blackwell.

Harrison, K. (2000). "The body electric: Thin-ideal media and eating disorders in adolescents." *Journal of Communication* **50**(3): 119-43.

Hatfield, A. B. and H. P. Lefley (1993). *Surviving mental illness: Stress, coping, and adaptation*. New York, Guilford Press.

Hawkings, J. R., K. S. Jones, et al. (1956). "Deliberate Disability." *British Medical Journal* **1**(4963): 361-367.

Hebebrand, J., R. Casper, et al. (2004). "The need to revise the diagnostic criteria for anorexia nervosa." *Journal of Neural Transmission* **111**(7): 827-40.

Heidegger, M. (1962). *Being and time*. New York, Harper.

Heinberg, L. J. and J. K. Thompson (1995). "Body image and televised images of thinness and attractiveness: A controlled laboratory investigation." *Journal of Social and Clinical Psychology* **14**(4): 325-338.

Helman, C. (1985). *Culture, health and illness: An introduction for health professionals*. Bristol, Wright.

Heppner, P. P., J. I. Rosenberg, et al. (1992). "Three methods in measuring the therapeutic process: Clients' and counselors' constructions of the therapeutic process versus actual therapeutic events." *Journal of Counseling Psychology* **39**(1): 20-31.

Hepworth, J. (1994). "Qualitative analysis and eating disorders: Discourse analytic research on anorexia nervosa." *The International Journal of Eating Disorders* **15**(2): 179-185.

Hepworth, J. (1999). *The social construction of anorexia nervosa*. London; Thousand Oaks, Calif., Sage Publications.

Herman, J. L. (1992). *Trauma and recovery*. New York: HarperCollins Publishers.

Herzog, D. B., M. B. Keller, et al. (1992). "Psychiatric comorbidity in treatment-seeking anorexics and bulimics." *Journal of the American Academy of Child & Adolescent Psychiatry* **31**(5): 810-818.

Herzog, D. B., K. M. Nussbaum, et al. (1996). "Comorbidity and outcomes in eating disorders." *Psychiatric Clinics of North America* **19**(4): 843-859.

Herzog, D. B., N. R. Sacks, et al. (1993). "Patterns and predictors of recovery in anorexia nervosa and bulimia nervosa." *Journal of the American Academy of Child and Adolescent Psychiatry* **32**(4): 835-42.

Herzog, W., H. C. Deter, et al. (1997). "Medical findings and predictors of long-term physical outcome in anorexia nervosa: A prospective, 12-year follow-up study." *Psychological Medicine* **27**(02): 269-279.

Hesse, E. (1996). "Discourse, memory, and the Adult Attachment Interview: A note with emphasis on the emerging cannot classify category." *Infant Mental Health Journal* **17**(1): 4-11.

Higbed, L. and J. R. E. Fox (2010). "Illness perceptions in anorexia nervosa: A qualitative investigation." *British Journal of Clinical Psychology* **49**(3): 307-325.

Higginson, I., P. Priest, et al. (1994). "Are bereaved family members a valid proxy for a patient's assessment of dying?" *Social Science & Medicine* **38**(4): 553-557.

Hilde, B. (1971). "Family transactions in eating disorders." *Comprehensive Psychiatry* **12**(3): 238-248.

Hinney A, Scherag S, et al. (2010). "Genetic findings in anorexia and bulimia nervosa." *Progress in Molecular Biolology and Translational Science* **94**: 241-70.

Holland, A. J., N. Sicotte, et al. (1988). "Anorexia nervosa: Evidence for a genetic basis." *Journal of Psychosomatic Research* **32**(6): 561-71.

Holliday, J., E. Wall, et al. (2005). "Perceptions of illness in individuals with anorexia nervosa: A comparison with lay men and women." *The International Journal of Eating Disorders* **37**(1): 50-6.

Hollway, W. and T. Jefferson (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. London; Thousand Oaks, Calif., SAGE.

Holstein, J. A. and J. F. Gubrium (1995). *The active interview*. Thousand Oaks, SAGE Publications.

Hornbacher, M. (1999). *Wasted : A memoir of anorexia and bulimia*. New York: HarperPerennial.

Horvath, A. O. and L. Luborsky (1993). "The role of the therapeutic alliance in psychotherapy." *Journal of Consulting and Clinical Psychology* **61**(4): 561-73.

Horvath, A. O. and B. D. Symonds (1991). "Relation between working alliance and outcome in psychotherapy: A meta-analysis." *Journal of Counseling Psychology* **38**(2): 139-49.

Hsu, L. K. (1988). "The outcome of anorexia nervosa: A reappraisal." *Psychological Medicine* **18**(4): 807-12.

Hsu, L. K., A. H. Crisp, et al. (1992). "Psychiatric diagnoses in recovered and unrecovered anorectics 22 years after onset of illness: A pilot study." *Comprehensive Psychiatry* **33**(2): 123-7.

Hsu, L. K., A. H. Crisp, et al. (1979). "Outcome of anorexia nervosa." *Lancet* **1**(8107): 61-5.

Hubble, M. A., B. L. Duncan, et al. (1999). *The heart & soul of change: What works in therapy*. Washington, DC, American Psychological Association.

Hunt, D. and J. A. Smith (2004). "The personal experience of carers of stroke survivors: An interpretative phenomenological analysis." *Disability and Rehabilitation* **26**(16): 1000-1011.

Husserl, E. (1927). *Encyclopedia Britanica*. London.

Hyden, L. C. (1997). "Illness and narrative." *Sociology of Health and Illness* **19**(1): 48-69.

IJzendoorn, v., M. H, et al. (1996). "Attachment representations in mothers, fathers, adolescents, and clinical groups: A meta-analytic search for normative data." *Journal of Consulting and Clinical Psychology* **64**(1): 8-21.

Jacobi, C., C. Hayward, et al. (2004). "Coming to terms with risk factors for eating disorders: Application of risk terminology and suggestions for a general taxonomy." *Psychological Bulletin* **130**(1): 19-65.

Jacobson, N. (2001). "Experiencing recovery: A dimensional analysis of recovery narratives." *Psychiatric Rehabilitation Journal* **24**(3): 248-56.

Jalal al-Din, R. and A. Schimmel (1991). *Look! This is love: poems of Rumi*. Boston; New York, Shambala ;Random House.

James, W. (1890). *The principles of psychology*. New York, H. Holt and Company.

Jarman, M. and S. Walsh (1999). "Evaluating recovery from anorexia nervosa and bulimia nervosa: Integrating lessons learned from research and clinical practice." *Clinical Psychology Review* **19**(7): 773-788.

Johnson, C., M. E. Connors, et al. (1987). "Symptom management of bulimia." *Journal of Consulting and Clinical Psychology* **55**(5): 668-76.

Jones, L. M., W. K. Halford, et al. (1993). "Long term outcome of anorexia nervosa." *Behaviour Change* **10**(2): 93-102.
Josselson, R. and A. Leiblich (1993). *The narrative study of lives*. London, Sage.

Kahn, R. L. and C. F. Cannel (1967). *The dynamics of interviewing: Theory, technique and cases*. New York, Wiley.

Kaplan, A. S. (2002). "Psychological treatments for anorexia nervosa: A review of published studies and promising new directions." *Canadian Journal of Psychiatry* **47**(3): 235-42.

Karwautz, A., S. Rabe-Hesketh, et al. (2001). "Individual-specific risk factors for anorexia nervosa: A pilot study using a discordant sister-pair design." *Psychological Medicine* **31**(2): 317-29.

Kathleen M, P. (1998). "Long-term course of anorexia nervosa: Response, relapse, remission, and recovery." *Clinical Psychology Review* **18**(4): 447-475.

Katzman, M. A. and S. Lee (1997). "Beyond body image: The integration of feminist and transcultural theories in the understanding of self starvation." *The International Journal of Eating Disorders* **22**(4): 385-94.

Katzman, M., K. Hermans, et al. (2004). "Not your "typical island woman": Anorexia Nervosa is reported only in subcultures in Curaçao." *Culture, Medicine and Psychiatry* **28**(4): 463-492.

Kelly, M. P. and H. Dickinson (1997). "The narrative self in autobiographical accounts of illness." *The Sociological Review* **45**(2): 254-278.

Kendall-Tackett, K. A., L. M. Williams, et al. (1993). "Impact of sexual abuse on children: A review and synthesis of recent empirical studies." *Psychological Bulletin* **113**(1): 164-180.

Kent, A. and G. Waller (2000). "Childhood emotional abuse and eating psychopathology." *Clinical Psychology Review* **20**(7): 887-903.

Keski-Rahkonen, A. and F. Tozzi (2005). "The process of recovery in eating disorder sufferers' own words: An Internet-based study." *The International Journal of Eating Disorders* **37**(S1): S80-S86.

Key, A., A. Obrien, et al. (2006). "Assessment of neurobiology in adults with anorexia nervosa." *European Eating Disorders Review* **14**(5): 308-314.

Keys, A (1950). *The biology of human starvation*. Minneapolis, University of Minnesota Press.

Kinderman, P., E. Setzu, et al. (2006). "Illness beliefs in schizophrenia." *Social Science & Medicine* **63**(7): 1900-1911.

Kirkwood, C. *Persons in relation perspective : in counselling, psychotherapy and community adult learning*. Rotterdam, Sense.

Kleinman, A. (1989). *The illness narratives: Suffering, healing, and the human condition*. New York, Basic Books.

Kong, S. and K. Bernstein (2009). "Childhood trauma as a predictor of eating psychopathology and its mediating variables in patients with eating disorders." *Journal of Clinical Nursing* **18**(13): 1897-1907.

Koubaa, S., T. Hällström, et al. (2008). "Early maternal adjustment in women with eating disorders." *The International Journal of Eating Disorders* **41**(5): 405-410.

Kraemer, H. C., A. E. Kazdin, et al. (1997). "Coming to terms with the terms of risk." *Archive of General Psychiatry* **54**(4): 337-343.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, Calif., Sage Publications.

Laing, R. D. and A. Esterson (1964). *Sanity, madness and the family. Volume I: Families of schizophrenics*. London, Tavistock Publications.

Lambert, M. J. (1976). "Spontaneous remission in adult neurotic disorders: A revision and summary." *Psychological Bulletin* **83**(1): 107-19.

Lambert, M. J. (2004). *Bergin and Garfield's handbook of psychotherapy and behavior change*. New York: Wiley.

Lambert, M. J., D. A. Shapiro, et al. (1986). Evaluation of therapeutic outcomes. *Handbook of psychotherapy and behaviour change*. S. L. Garfield and A. E. Bergin. New York, Wiley.

Lamoureux, M. M. H. and J. L. Bottorff (2005). "Becoming the real me": Recovering from Anorexia Nervosa." *Health Care for Women International* **26**(2): 170-188.

Langellier, K. M. and E. E. Peterson (2006). ""Somebody's got to pick eggs": Family storytelling about work." *Communication Monographs* **73**(4): 468-473.

Langley, J. (2006). *Boys get anorexia too: Coping with male eating disorders in the family*. London; SAGE.

Lapsley, H., L. W. Nikora, et al. (2002). *"Kia Mauri Tau!" : Narratives of recovery from disabling mental health problems*. Wellington, New Zealand, Mental Health Commission.

Larkin, M. and M. D. Griffiths (2002). "Experiences of addiction and recovery: The case for subjective accounts." *Addiction Research and Theory* **10**(3): 281-311.

Lask, B. and R. Bryant-Waugh (2000). *Anorexia nervosa and related eating disorders in childhood and adolescence*. Hove, East Sussex, UK, Psychology Press.

Launer, J. M. N. (2002). *Narrative-based primary care: A practical guide*. Abingdon, Radcliffe Medical Press.

Lawrence, M. and W. Pennycook (1984). *The anorexic experience*. London, Women's Press.

Lee, S. (1995). "Self-starvation in context: Towards a culturally sensitive understanding of anorexia nervosa." *Social Science & Medicine* (1982) **41**(1): 25-36.

Le Grange, D., J. Lock, et al. (2010). "Academy for eating disorders position paper: The role of the family in eating disorders." *The International Journal of Eating Disorders* **43**(1):1-5.

Leight, S. B. (2002). "Starry night: Using story to inform aesthetic knowing in women's health nursing." *Journal of Advanced Nursing* **37**(1): 108-114.

Léonard, S., H. Steiger, et al. (2003). "Childhood and adulthood abuse in bulimic and non-bulimic women: Prevalences and psychological correlates." *The International Journal of Eating Disorders* **33**(4): 397-405.

Leventhal, H., Nerenz, D., & Steele, D. (1984). Illness representation and coping with health threats. *A Handbook of Psychology and Health*. A. Baum and J. Singer. Hillsdale, NJ, Erlbaum. **4:** 219-252.

Lieblich, A., R. Tuval-Mashiach, et al. (1998). *Narrative research: Reading, analysis and interpretation*. Thousand Oaks, Calif, Sage Publications.

Liebrich, J., T. Adams, et al. (1999). *A gift of stories: Discovering how to deal with mental illness*. Ottawa, University of Ottawa Press.

Linehan, M. M. (1987). "Dialectical behavior therapy for borderline personality disorder. Theory and method." *Bulletin of the Menninger Clinic* **51**(3): 261-76.

Lord, S. A. (2008). "Therapeutic work with trauma, revictimization, and perpetration: Bearing witness, offering hope, embracing despair." *Psychoanalytic Social Work* **15**(2): 110-131.

Lowe, B., S. Zipfel, et al. (2001). "Long-term outcome of anorexia nervosa in a prospective 21-year follow-up study." *Psychological Medicine* **31**(5): 881-890.

Lynch, G. (1997). "Therapeutic theory and social context: A social constructionist perspective." *British Journal of Guidance and Counselling* **25**(1): 5-15.

Lyons-Ruth, K. (1998). "Attachment and Psychopathology. Edited by L. Atkinson and K. Zucker." *Infant Mental Health Journal*. **19**(4): 451.

MacDonald, J., V. Sinason, et al. (2003). "An interview study of people with learning disabilities' experience of, and satisfaction with, group analytic therapy." *Psychology and Psychotherapy: Theory, Research and Practice* **76**(4): 433-453.

MacIntyre, A. C. (1981). *After virtue: A study in moral theory*. Notre Dame, Ind., University of Notre Dame Press.

MacSween, M. (1993.). *Anorexic bodies: A feminist and sociological perspective on anorexia nervosa*. London; New York: Routledge.

Main, M. and J. Soloman (1986). Discovery of an insecure-disorganised/ disorientated attachment pattern. *Affective development in infancy*. T. Berry and M. W. Yogman. Westport, Ablex**:** 95-124.

Maria, D. and K. A. Halmi (1992). "Classifications of anorexia nervosa: Question of subtypes." *The International Journal of Eating Disorders* **11**(4): 305-313.

Martin, D. J., J. P. Garske, et al. (2000). "Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review." *Journal of Consulting and Clinical Psychology* **68**(3): 438-50.

Marziali, E. (1984). "Three viewpoints on the therapeutic alliance. Similarities, differences, and associations with psychotherapy outcome." *The Journal of Nervous and Mental Disease* **172**(7): 417-23.

Masterson, J. (1977). *Primary anorexia nervosa in the borderline adolescent: An object relations view - Borderline personality disorders*. New York, International Universities Press.

Matsunaga, H., W. H. Kaye, et al. (2000). "Personality disorders among subjects recovered from eating disorders." *The International Journal of Eating Disorders* **27**(3): 353-7.

Mattingly, C. (1998). *Healing dramas and clinical plots: The narrative structure of experience*. Cambridge: Cambridge University Press.

Mattingly, C. and L. C. Garro (2000). *Narrative and the cultural construction of illness and healing*. Berkeley, University of California Press.

Mayo, N. E., S. C. Scott, et al. (2001). "Waiting time for breast cancer surgery in Quebec." *Canadian Medical Association Journal* **164**(8): 1133-1138.

Mazure, C. M., K. A. Halmi, et al. (1994). "The Yale-Brown-Cornell Eating Disorder Scale: Development, use, reliability and validity." *Journal of Psychiatric Research* **28**(5).

Mazzeo, S. E. and D. L. Espelage (2002). "Association between childhood physical and emotional abuse and disordered eating behaviors in female undergraduates: An investigation of the mediating role of alexithymia and depression." *Journal of Counseling Psychology* **49**(11): 86-100.

McAdams, D. P. (1993). *The stories we live by: Personal myths and the making of the self*. New York: Morrow.

McCabe, M. P., L. A. Ricciardelli, et al. (2007). "Where is all the pressure coming from? Messages from mothers and teachers about preschool children's appearance, diet and exercise." *European Eating Disorders Review* **15**(3): 221-230.

McIntosh, V. V., C. M. Bulik, et al. (2000). "Interpersonal psychotherapy for anorexia nervosa." *The International Journal of Eating Disorders* **27**(2): 125-39.

McLeod, J. (1997). *Narrative and psychotherapy*. London; Thousand Oaks, Calif., Sage Publications.

McLoyd, V. C. and L. D. Steinberg (1998). *Studying minority adolescents : Conceptual, methodological and theoretical issues*. Mahwah (N.J.), L.Erlbaum.

McManus, F. and G. Waller (1995). "A functional analysis of binge-eating." *Clinical Psychology Review*. **15**(8): 845.

Merleau-Ponty, M. (1962). *Phenomenology of perception*. New York, Humanities Press.
Miller, G. and R. Dingwall (1997). *Context and method in qualitative research*. London, Sage Publications.

Miller, J. and B. Glassner (1997). The inside and the outside: Finding realities in interviews. *Qualitative Research Theory, Method and Practice*. D. Silverman. London, Sage**:** 56-98.

Miller, M. N. and A. s. J. Pumariega (2001). "Culture and eating disorders: A historical and cross-cultural review." *Psychiatry: Interpersonal and Biological Processes* **64**(2): 93-110.

Miller, W. R. and S. Rollnick (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, Guilford Press.

Miller, W. R. and S. Rollnick (2009). "Ten things that motivational interviewing is not." *Behavioural and Cognitive Psychotherapy* **37**(02): 129-140.

Minuchin, S. (1978). *Psychosomatic families: Anorexia nervosa in context*. Cambridge, MA, Harvard University Press.

Mishler, E. (2005). "Patient stories, narratives of resistance and the ethics of humane care: A la recherche du temps perdu." *Health* **9**(4): 431-451.

Mishler, E., J. Clark, et al. (1989). "The language of attentive patient care." *Journal of General Internal Medicine* **4**(4): 325-335.

Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews*. Norwood, N.J., Ablex Publishers.

Mishler, E. G. (1986). *Research interviewing: Context and narrative*. Cambridge, Mass., Harvard University Press.

Montigny, R. (1948). *J.-P. Sarte et l'existentialisme ou le problème de la littérature philosophique*. Lindau am Bodensee, Frisch & Perneder.

Moran, D. (2000). *Introduction to phenomenology*. London; New York, Routledge.

Morgan, D. L. (1988). *Focus groups as qualitative research*. Newbury Park, Calif., Sage Publications.

Morgan, H. G. and G. F. Russell (1975). "Value of family background and clinical features as predictors of long-term outcome in anorexia nervosa: Four-year follow-up study of 41 patients." *Psychological Medicine* **5**(4): 355-71.

Morgan, K. A. (2000). *Myth and philosophy from the Presocratics to Plato*. Cambridge; New York, Cambridge University Press.

Morgan, P. and L. Institute of Economic Affairs (1996). *Who needs parents? The effects of childcare and early education on children in Britain and the USA.* Choice in Welfare Series No. 31, Institute of Economic Affairs, London.

Morrison, T., G. Waller, et al. (2003). "Social comparison in the eating disorders." *The Journal of Nervous and Mental Disease* **191**(8): 553-555.

Morrison, T. G., R. Kalin, et al. (2004). "Body-image evaluation and body-image investment among adolescents: A test of sociocultural and social comparison theories." *Adolescence* **39**(155): 571-92.

Murphy, S., L. Russell, et al. (2005). "Integrated psychodynamic therapy for bulimia nervosa and binge eating disorder: Theory, practice and preliminary findings." *European Eating Disorders Review* **13**(6): 383-391.

Murray, C. and G. Waller (2002). "Reported sexual abuse and bulimic psychopathology among nonclinical women: The mediating role of shame." *The International Journal of Eating Disorders* **32**(2): 186-191.

Myers, L. B. and C. R. Brewin (1996). "Illusions of well-being and the repressive coping style." *The British Journal of Social Psychology* **35**:443-57.

National Institute for Health and Clinical Excellence, NICE (2004) *"Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders."* National Collaborating Centre for Mental Health, Gaskell.

NHS Executive (2000). *National Service Framework for Mental Health: Standards and Service Models.* London: NHS Executive.

Nielsen, S. (2001). "Epidemiology and mortality of eating disorders." *The Psychiatric Clinics of North America* **24**(2): 201-14.

Newton, E., M. Larkin, et al. (2007). "More than just a place to talk: Young people's experiences of group psychological therapy as an early intervention for auditory hallucinations." *Psychology and Psychotherapy: Theory, Research and Practice* **80**(1): 127-149.

Newton, J. T., P. H. Robinson, et al. (1993). "Treatment for eating disorders in the United Kingdom. Part II. Experiences of treatment: A survey of members of the eating disorders association." *European Eating Disorders Review* **1**(1): 10-21.

NHS Quality Improvement Scotland (2006). *Eating disorders in Scotland: Recommendations for Management and Treatment.* Edinburgh: NHS QIS.

Nicholls, D. E. and R. M. Viner (2009). "Childhood risk factors for lifetime Anorexia Nervosa by age 30 years in a national birth cohort." *Journal of the American Academy of Child & Adolescent Psychiatry* **48**(8): 791-799.

Nilsson, K (2006). "Patient perspectives of recovery in adolescent onset Anorexia Nervosa." *Eating Disorders* **14**(4): 305-311.

Norcross, J. C. (1986). *Handbook of eclectic psychotherapy*. New York: Brunner/Mazel.
Norcross, J. C. and M. R. Goldfried (1992). *Handbook of Psychotherapy Integration*. New York: BasicBooks.

Norcross, J. C. and L. M. Grencavage (1989). "Eclecticism and integration in counselling and psychotherapy: Major themes and obstacle." *British Journal of Guidance & Counselling* **17**(3): 227-247.

O'Kearney, R. (1996). "Attachment disruption in anorexia nervosa and bulimia nervosa: A review of theory and empirical research." *The International Journal of Eating Disorders* **20**(2): 115-127.

Office for National Statistics (2000). Section 3: Services Profile 1: Overview of Eating Disorders.

Orbach, S. (1978). *Fat is a Feminist Issue: The anti-diet guide to permanent weight loss* London, Randomhouse.

Orbach, S. (1986). *Hunger Strike*. London, Faber and Faber.

Owen, J. B., J. Treasure, et al. (2001). *Animal models - disorders of eating behaviour and body composition*. Dordrecht; Boston, Kluwer Academic Publishers.

Paley, J. and G. Eva (2005). "Narrative vigilance: The analysis of stories in health care." *Nursing Philosophy* **6**(2): 83-97.

Palmer, B. (2003). Concepts of eating disorders. *Handbook of Eating Disorders.* J. Treasure, U. Schmidt and E. v. Furth. London, John Wiley & Sons.

Palmer, B. (2006). "Come the revolution." *Advances in Psychiatric Treatment* **12**(1): 5-12.

Palmer, R. L. (2000). *Helping people with eating disorders: A clinical guide to assessment and treatment*. Chichester; New York, Wiley.

Papadopoulos, F. C., A. Ekbom, et al. (2009). "Excess mortality, causes of death and prognostic factors in anorexia nervosa." *The British Journal of Psychiatry* **194**(1): 10-17.

Parker, G. (1983). *Parental overprotection : A risk factor in psychosocial development*. New York, Grune & Stratton.

Parr, H. (1998). "The politics of methodology in 'post-medical geography': Mental health research and the interview." *Health & Place* **4**(4): 341-53.

Parry, G. (2000). "Developing treatment choice guidelines in psychotherapy." *Journal of Mental Health* **9**(3): 273-281.

Paterson, G., K. Power, et al. (2007). "The relationship between two-dimensional self-esteem and problem solving style in an anorexic inpatient sample." *European Eating Disorders Review* **15**(1): 70-77.

Peterson, E. E. and K. Langellier (2006). "The performance turn in narrative studies." *Narrative Inquiry* **16**(1): 173-180.

Pettersen, G. and J. H. Rosenvinge (2002). "Improvement and recovery from eating disorders: A patient perspective." *Eating Disorders* **10**(1): 61-71.

Pietrini, F., G. Castellini, et al. "Functional neuroimaging in anorexia nervosa: A clinical approach." *European Psychiatry* **26**(3): 176-182.

Pietromonaco, P. R. and D. Greenwood (2004). Conflict in adult close relationships: An attachment perspective. *Adult attachment: New directions and emerging issues*. W. S. Rholes and J. A. Simpson. New York, Guilford Press.

Pike, K. M., A. Hilbert, et al. (2008). "Toward an understanding of risk factors for anorexia nervosa: A case-control study." *Psychological Medicine* **38**(10): 1443-1453.

Pike, K. M. (1998). "Long-term course of anorexia nervosa: response, relapse, remission, and recovery." *Clinical Psychology Review* **18**(4): 447-75.

Plummer, K. (2001). *Documents of life 2: An invitation to a critical humanism*. London; Thousand Oaks, Calif., Sage Publications.

Poland, W. S. (2000). "The analyst's witnessing and otherness." *Journal of the American Psychoanalytic Association* **48**(1): 17-34.

Polkinghorne, D. E. (1984). "Further extensions of methodological diversity for counseling psychology." *Journal of Counseling Psychology* **31**(4): 416-429.

Powell, J. J. (1969). *Why am I afraid to tell you who I am? (Insights on self-awareness, personal growth and interpersonal communication)*. Chicago, Argus Communications.

Prochaska, J. O. and C. C. Diclemente (1982). "Transtheoretical therapy: Towards a more integrative model of change." *Psychotherapy: Theory, Research & Practice* **19**(3): 276-288.

Prochaska, J. O., C. C. DiClemente, et al. (1992). "In search of how people change. Applications to addictive behaviors." *The American psychologist* **47**(9): 1102-14.

Rabin, A. I. and M. Haworth (1960). *Projective techniques with children*. New York, Grune & Stratton.

Rachman, S. and G. T. Wilson (1980). *The effects of psychological therapy*. Oxford; New York, Pergamon Press.

Rayworth, B. B., L. A. Wise, et al. (2004). "Childhood abuse and risk of eating disorders in women." *Epidemiology* **15**(3): 271-278.

Reid, K., P. Flowers, et al. (2005). "Exploring lived experience: An introduction to interpretative phenomenological analysis." *The Psychologist*. **18**(1): 20-25.

Ribas, M., Gratas, M., et al. (2004). "Association of BDNF with anorexia, bulimia and age of onset of weight loss in six European populations." *Human Molecular Genetics* **13**(12): 1205-1212.

Ricoeur, P. (1977). Towards a hermeneutic of the idea of revelation. *The Harvard Theological Review* **70** (1/2):1-37.

Ricoeur, P. and J. B. Thompson (1984). *Hermeneutics and the human sciences: Essays on language, action and interpretation*. Cambridge; Cambridge University Press.

Ridgway, P. (2001). "Restorying psychiatric disability: learning from first person recovery narratives." *Psychiatric Rehabilitation Journal* **24**(4): 335-43.

Rieger, E., S. Touyz, et al. (2000). "Development of an instrument to assess readiness to recover in anorexia nervosa." *The International Journal of Eating Disorders* **28**(4): 387-96.

Rieger, E., S. W. Touyz, et al. (2002). "The Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ): Information regarding its psychometric properties." *The International Journal of Eating Disorders* **32**(1): 24-38.

Riessman, C. K. (1990). *Divorce talk: Women and men make sense of personal relationships*. New Brunswick, Rutgers University Press.
Riessman, C. K. (1993). *Narrative analysis*. Newbury Park, CA, Sage Publications.
Riessman, C. K. (2003). "Performing identities in illness narrative: Masculinity and multiple sclerosis." *Qualitative Research* **3**(1): 5-33.

Riessman, C. K. (2005). "Exporting ethics: A narrative about narrative research in South India." *Health:* **9**(4): 473-490.

Rind, B., P. Tromovitch, et al. (1998). "A meta-analytic examination of assumed properties of child sexual abuse using college samples." *Psychological Bulletin* **124**(1): 22-53.

Ringer, F. and P. M. Crittenden (2007). "Eating disorders and attachment: the effects of hidden family processes on eating disorders." *European Eating Disorders Review* **15**(2): 119-130.

Roberts, G. (2000). “Narrative and severe mental illness: What place do stories have in an evidence-based world?”. *Advances in Psychiatric Treatment* **6**: 432-441.

Roberts, G. and P. Wolfson (2004). “The rediscovery of recovery: open to all”. *Advances in Psychiatric Treatment* **10**: 37-48.

Robinson, I. (1990). "Personal narratives, social careers and medical courses: Analysing life trajectories in autobiographies of people with multiple sclerosis." *Social Science & Medicine* **30**(11): 1173-1186.

Robinson, P. H. and M. A. Serfaty (2001). "The use of e-mail in the identification of bulimia nervosa and its treatment." *European Eating Disorders Review* **9**(3): 182-193.

Rodgers, R. and H. Chabrol (2009). "Parental attitudes, body image disturbance and disordered eating amongst adolescents and young adults: A review." *European Eating Disorders Review* **17**(2): 137-151.

Rodríguez, M., V. Pérez, et al. (2005). "Impact of traumatic experiences and violent acts upon response to treatment of a sample of Colombian women with eating disorders." *The International Journal of Eating Disorders* **37**(4): 299-306.

Rogers, C. R. (1968). *The interpersonal relationship in the facilitation of learning*. Columbus, Ohio, C.E. Merrill Publishers.

Roose, G. A. and A. M. John (2003). "A focus group investigation into young children's understanding of mental health and their views on appropriate services for their age group." *Child: Care, Health & Development* **29**(6): 545-550.

Rorty, M., J. Yager, et al. (1993). "Why and how do women recover from bulimia nervosa? The subjective appraisals of forty women recovered for a year or more." *The International Journal of Eating Disorders* **14**(3): 249-260.

Roth, A. and P. Fonagy (2005). *What works for whom? A critical review of psychotherapy research*. New York, Guilford Press.

Rushford, N. (2006). "Readiness to recover in anorexia nervosa: What does it depend on in female inpatients?" *European Eating Disorders Review* **14**(6): 388-396.

Russell, G. (1970). *Anorexia nervosa: Its identity as an illness and its treatment - Modern trends in psychological medicine*. London, Butterworth.

Russell, G. (1995). “*Anorexia nervosa through time”*. Handbook of eating disorders. Chichester, John Wiley: 5-17.

Ryle, A. (1995). *Cognitive analytic therapy: Developments in theory and practice*. Chichester; New York, Wiley.

Ryle, A. and I. B. Kerr (2002). *Introducing cognitive analytic therap : Principles and practice*. Chichester, West Sussex, Wiley.

Saen, N. (2001). "Epidemiology and mortality of eating disorders." *Psychiatric Clinics of North America* **24**(2): 201-214.

Saccomani, L., M. Savoini, et al. (1998). "Long-term outcome of children and adolescents with anorexia nervosa: Study of comorbidity." *Journal of Psychosomatic Research* **44**(5): 565-571.

Sacks, H. and G. Jefferson (1992). *Lectures on conversation*. Oxford, UK; Cambridge, Mass., Blackwell.

Sakalys, J. A. (2000). "The political role of illness narratives." *Journal of Advanced Nursing* **31**(6): 1469-75.

Salzman, J. P. (1988). *Primary attachment at adolescence and female identity: An extension of Bowlby's perspective*. Thesis (Ed.D). Harvard Graduate School of Education.

Salzman, J. P. (1997). "Ambivalent attachment in female adolescents: Association with affective instability and eating disorders." *The International Journal of Eating Disorders* **21**(3): 251-259.

Sandelowski, M. (1993). "Rigor or rigor mortis: the problem of rigor in qualitative research revisited." ANS. *Advances in nursing science* 16(2): 1-8.

Sartre, J.P. (1948). *The psychology of imagination*. New York, Philosophical Library.

Sartre, J.P. (1965). *Situations.* New York, G. Braziller.

Sartre, J.P. (1969). *Being and nothingness: An essay on phenomenological ontology*. London, Routledge.

Sarup, M. and T. Raja (1996). *Identity, culture and the postmodern world*. Edinburgh, Edinburgh University Press.

Scherag, S., J. Hebebrand, et al (2010) "Eating disorders: The current status of molecular genetic research." *European Child & Adolescent Psychiatry* **19**(3): 211-226.

Schiraldi, G. R. (2000). "The post-traumatic stress disorder sourcebook: A guide to healing, recovery, and growth." New York: McGraw-Hill.

Schleiermacher, F. and A. Bowie (1998). *Schleiermacher: "Hermeneutics and criticism"*. Cambridge, Cambridge University Press.

Schmidt, U., J. Tiller, et al. (1997). "Is there a specific trauma precipitating anorexia nervosa?" *Psychological Medicine* **27**(03): 523-530.

Schmidt, U. and J. Treasure (2006). "Anorexia nervosa: Valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice." *British Journal of Clinical Psychology* **45**(3): 343-366.

Schork, E. J., E. D. Eckert, et al. (1994). "The relationship between psychopathology, eating disorder diagnosis, and clinical outcome at 10-year follow-up in anorexia nervosa." *Comprehensive Psychiatry* **35**(2).

Schwandt, T. A. (1997). *Qualitative inquiry: A dictionary of terms*. Thousand Oaks, Sage Publications.

Schwandt, T. A. (2001). *Dictionary of qualitative inquiry*. Thousand Oaks, Calif., Sage Publications.

Schwartz, M. F. and P. Gay (1993). "Physical and sexual abuse and neglect and eating disorder symptoms." *Eating Disorders* **1**(3-4): 265-281.

Sclater, S. D. (1999). *Divorce: A psychosocial study*. Aldershot, Hants, England; Brookfield, Vt., USA, Ashgate.

Seidman, I. (1991). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. New York, Teachers College Press.

Selvini Palazzoli, M. (1978). *Self-starvation: From individual to family therapy in the treatment of anorexia nervosa*. New York, J. Aronson.

Shaw, I. F. (2003). "Ethics in qualitative research and evaluation." *Journal of Social Work* **3**(1): 9-29.

Shaw, I and N. Gould (2001). *Qualitative research in social work.* London, Sage.

Shinebourne, P. and J. A. Smith "The communicative power of metaphors: An analysis and interpretation of metaphors in accounts of the experience of addiction." *Psychology and Psychotherapy: Theory, Research and Practice* **83**(1): 59-73.

Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York, Guilford Press.

Silverman, D. (1993). *Interpreting qualitative data: Methods for analysing talk, text, and interaction*. London; Thousand Oaks.

Silverman, D. (1997). *Qualitative research: Theory, method, and practice*. London; Thousand Oaks.

Skarderud, F. (2009). "Bruch revisited and revised." *European Eating Disorders Review* **17**(2): 83-88.

Slade, P. (1982). "Towards a functional analysis of anorexia nervosa and bulimia nervosa." *British Journal of Clinical Psychology* **21**(3): 167-179.

Smith, J. A. (1993). The Case Study: *Counselling and Psychology for Health Professionals*. R. Bayne and P. Nicolson. London, Chapman Hall.

Smith, J. A. (1996). "Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology." *Psychology & Health* **11**(2): 261-271.

Smith, J. A.,Flowers, P., et al. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London, Sage.

Smith, J. A.,Flowers, P.,et al. (1997). Interpretative phenomenological analysis and health psychology. In L.Yardly (Eds.), *Material Discourses & Health*. London, Routledge.

Smith, J. A. and M. Osborn (2008). Interpretative Phenomenological Analysis. In J.A Smith (Ed.), *Qualitative Psychology: A practical guide to methods.* London: Sage.

Smolak, L. and S. K. Murnen (2002). "A meta-analytic examination of the relationship between child sexual abuse and eating disorders." *The International Journal of Eating Disorders* **31**(2): 136-150.

Spiegelberg, H. and K. Schuhmann (1982). *The phenomenological movement: A historical introduction*. Hague; Boston; Hingham.

Steiger, H., J. V. D. Feen, et al. (1989). "Defense styles and parental bonding in eating-disordered women." *The International Journal of Eating Disorders* **8**(2): 131-140.

Stein, K. F. and C. Corte (2007). "Identity impairment and the eating disorders: Content and organization of the self-concept in women with anorexia nervosa and bulimia nervosa." *European Eating Disorders Review* **15**(1): 58-69.

Steinhausen, H. C. (1999). Eating disorders. *Risks and outcomes in developmental psychopathology*. H. C. Steinhausen and F. Verhulst. Oxford, Oxford University Press.

Steinhausen, H. C. (2002). "The outcome of anorexia nervosa in the 20th century." *The American Journal of Psychiatry* **159**(8): 1284-93.

Steinhausen, H. C., C. Rauss-Mason, et al. (1991). "Follow-up studies of anorexia nervosa: A review of four decades of outcome research." *Psychological Medicine* **21**(2): 447-54.

Steinhausen, H.-C. and R. Seidel (1993). "Outcome in adolescent eating disorders." *The International Journal of Eating Disorders* **14**(4): 487-496.

Stern, D. N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York, Basic Books.

Stern, D. N., L. W. Sander, et al. (1998). "Non-interpretive mechanisms in psychoanalytic therapy. The 'something more' than interpretation. The Process of Change Study Group." *The International Journal of Psychoanalysis* **79**: 903-21.

Stice, E., E. Schupak-Neuberg, et al. (1994). "Relation of media exposure to eating disorder symptomatology: An examination of mediating mechanisms." *Journal of Abnormal Psychology* **103**(4): 836-40.

Stice, E. and H. E. Shaw (1994). "Adverse effects of the media portrayed thin-ideal on women and linkages to bulimic symptomatology." *Journal of Social and Clinical Psychology* **13**(3): 288-308.

Stone-Mediatore, S. (2003). *Reading across borders: Storytelling and knowledges of resistance*. New York, Macmillan.

Strauss, A. L. and J. M. Corbin (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, California, Sage Publications.

Strober, M. (2004). "Managing the chronic, treatment-resistant patient with anorexia nervosa." *The International Journal of Eating Disorders* **36**(3): 245-55.

Strober, M. (2005). "The future of treatment research in Anorexia Nervosa." *The International Journal of Eating Disorders* **37**:90-94.

Strober, M., R. Freeman, et al. (1997). "The long-term course of severe anorexia nervosa in adolescents: Survival analysis of recovery, relapse, and outcome predictors over 10-15 years in a prospective study." *The International Journal of Eating Disorders* **22**(4): 339- 60.

Strupp, H. H. and S. W. Hadley (1978). "A tripartite model of mental health and therapeutic outcomes with special reference to negative effects in psychotherapy." *Educational Horizons* **57**(1): 35-41.

Susser, M. W. and W. Watson (1963). *Sociology in medicine*. London; New York, Oxford University Press.

Swain, T., et al. (1984). "A comparison of lenient and strict operant conditioning programmes in refeeding patients with anorexia nervosa." *British Journal of Psychiatry* **144**: 517–520.

Swanson, H., K. Power, et al. (2010). "The relationship between parental bonding, social problem solving and eating pathology in an anorexic inpatient sample." *European Eating Disorders Review* **18**(1): 22-32.

Swartz, S. and L. Swartz (1987). "Talk about talk: Metacommentary and context in the analysis of psychotic discourse." *Culture, Medicine and Psychiatry* **11**(4): 395-416.

Szasz, T. (1971). *The myth of mental illness: Foundations of a theory of personal conduct*. New York: Dell.

Szasz, T. S. (1972). "Bad habits are not diseases." *The Lancet* **300** (7767): 83-84.

Szmukler, G (Ed.); Dare, C (Ed); Treasure, J (Ed.) (1995). *Handbook of eating disorders: Theory, treatment and research.* Oxford, England: John Wiley.

Tan, J., Hope, T. et al. (2003). "Anorexia nervosa and personal identity: The accounts of patients and their parents." *International Journal of Law and Psychiatry* **26**(5).

Tchanturia, K., M. B. Anderluh, et al. (2004). "Cognitive flexibility in anorexia nervosa and bulimia nervosa." *Journal of the International Neuropsychological Society* **10**(04): 513-520.

Thomas, G. V. and A. M. J. Silk (1990). *An introduction to the psychology of children's drawings*. New York, New York University Press.

Thomas, S. P. and H. R. Pollio (2002). *Listening to patients: A phenomenological approach to nursing research and practice*. New York: Springer.

Thompson, J. K. (1999). *Exacting beauty: Theory, assessment, and treatment of body image disturbance*. Washington, DC, American Psychological Association.

Thompson, J. K., M. D. Coovert, et al. (1999). "Body image, social comparison, and eating disturbance: a covariance structure modeling investigation." *The International Journal of Eating Disorders* **26**(1): 43-51.

Thornhill, H., L. Clare, et al. (2004). "Escape, enlightenment and endurance." *Anthropology & Medicine* **11**(2): 181-199.

Tierney, S. (2004). "Evidence-based practice, research and anorexia: The what, the whys and the hurdles." *The International Journal of Psychiatric Nursing Research* **9**(3): 1100-9.

Tierney, S. and J. R. E. Fox (2010). "Living with the 'anorexic voice': A thematic analysis." *Psychology and Psychotherapy: Theory, Research and Practice* **83**(3): 243-254.

Tiggemann, M. and B. McGill (2004). "The role of social comparison in the effect of magazine advertisements on women's mood and body dissatisfaction." *Journal of Clinical Psychology* **23**(1): 23.

Tobin, D. L., C. Johnson, et al. (1991). "Multifactorial assessment of bulimia nervosa." *Journal of Abnormal Psychology* **100** (1): 14-21.

Todres, L. (2007). *Embodied enquiry : phenomenological touchstones for research, psychotherapy, and spirituality.* Houndmills, Basingstoke, Hampshire; new yor, Palgrave Macmillan.

Touyz, S. W., P. J. Beumont, et al. (1984). "A comparison of lenient and strict operant conditioning programmes in refeeding patients with anorexia nervosa." *The British Journal of Psychiatry* **144**(5): 517-20.

Tozzi, F., P. F. Sullivan, et al. (2003). "Causes and recovery in anorexia nervosa: the patient's perspective." *The International Journal of Eating Disorders* **33**(2): 143-54.

Treasure, J., K. Tchanturia, et al. (2005). "Developing a model of the treatment for eating disorder: Using neuroscience research to examine the how rather than the what of change." *Counselling and Psychotherapy Research* **5**(3): 191-202.

Tronick, E. (2007). *The neurobehavioral and social-emotional development of infants and children*. New York, W.W. Norton & Co.

Turner, A., J. Barlow, et al. (2002). "Play hurt, live hurt: Living with and managing osteoarthritis from the perspective of ex-professional footballers." *Journal of Health Psychology* **7**(3): 285-301.

Ullma, C. (2006). "Bearing witness: Across the barriers in society and in the clinic." *Psychoanalytic Dialogues.* **16**(2): 181.

Van Manen, M. (1990). *Researching lived experience : human science for an action sensitive pedagogy.* [Albany, N.Y], State University of New York Press.

Van Manen, M. (2003). *The tone of teaching : the language of pedagogy.* London, Ont.; Linton, Althouse ; Book Systems Plus

Vansteenkiste, M., B. Soenens, et al. (2005). "Motivation to change in eating disorder patients: A conceptual clarification on the basis of self-determination theory." *The International Journal of Eating Disorders* **37**(3): 207-219.

Velleman, D. J. (2003). "Narrative explanation." *The Philosphical Review* **112**(1).

Vincent, M. A. and M. P. McCabe (2000). "Gender differences among adolescents in family and peer influences on body dissatisfaction, weight loss, and binge eating behaviors." *Journal of Youth and Adolescence* **29**(2): 205-221.

Vitiello, B. and I. Lederhendler (2000). "Research on eating disorders: Current status and future prospects." *Biological Psychiatry* **47**(9): 777-786.

Vitousek, K., DeViva, et al. (1995). Concerns about changes in eating and anxieties disorders. *American Eating Disorders Academy: Annual Meeting*. New York.

Vitousek, K. and F. Manke (1994). "Personality variables and disorders in anorexia nervosa and bulimia nervosa." *Journal of Abnormal Psychology* **103**(1): 137-47.

Vitousek, K., S. Watson, et al. (1998). "Enhancing motivation for change in treatment-resistant eating disorders." *Clinical Psychology Review* **18**(4): 391-420.

Von Beltz, H. and P. Copeland (1996). *My soul purpose: Living, learning, and healing*. New York, Random House.

Wade, T. D. and J. Lowes (2002). "Variables associated with disturbed eating habits and overvalued ideas about the personal implications of body shape and weight in a female adolescent population." *The International Journal of Eating Disorders* **32**(1): 39-45.

Waller, G. (1993). "Sexual abuse and eating disorders. Borderline personality disorder as a mediating factor?" *The British Journal of Psychiatry* **162**: 771-5.

Wallin, D. J. (2007). *Attachment in psychotherapy*. New York, Guilford Press. Walsh, B. T. (2008). "Recovery from eating disorders." *The Australian and New Zealand Journal of Psychiatry* **42**(2): 95-6.

Ward, A. and S. Gowers (2005). Attachment and childhood development. *Handbook of Eating Disorders*, John Wiley & Sons, Ltd**:** 103-120.

Ward, A., R. Ramsay, et al. (2000). "Attachment patterns in eating disorders: Past in the present." *The International Journal of Eating Disorders* **28**(4): 370-376.

Ward, A., R. Ramsay, et al. (2001). "Attachment in anorexia nervosa: A transgenerational perspective." *British Journal of Medical Psychology* **74**(4): 497-505.

Ward, A., N. Troop, et al. (1996). "To change or not to change- 'how' is the question?" *The British Journal of Medical Psychology* **69**: 139-46.

Weaver, K., J. Wuest, et al. (2005). "Understanding womens' journey of recovering from Anorexia Nervosa." *Qualitative Health Research* **15**(2): 188-206.

Weingarten, K. (2000). "Witnessing, wonder, and hope". *Family Process* **39**(4): 389-402.

Weissman, M. M., J. C. Markowitz, et al. (2000). *Comprehensive guide to interpersonal psychotherapy*. New York, Basic Books.

Whitehouse, A. M., C. P. Freeman, et al. (1988). "Body size estimation in anorexia nervosa." *The British Journal of Psychiatry. Supplement*(2): 23-6.

Whitney, J., A. Easter, et al. (2008). "Service-users' feedback on cognitive training in the treatment of anorexia nervosa: A qualitative study." *The International Journal of Eating Disorders* **41**(6): 542-50.

Willig, C. (2001). *Introducing qualitative research in psychology. Adventures in theory & method.* Buckingham, Phil., Open Univ. Press.

Wilson, R. F. (1999). *Handbook of trauma: Pitfalls and pearls*. Philadelphia, Lippincott Williams & Wilkins.

Windauer, U., W. Lennerts, et al. (1993). "How well are 'cured' anorexia nervosa patients? An investigation of 16 weight-recovered anorexic patients." *The British Journal of Psychiatry* **163**: 195-200.

Wisniewski, L. and E. Kelly (2003). "The application of dialectical behavior therapy to the treatment of eating disorders." *Cognitive and Behavioral Practice* **10**(2): 131-138.

Wolf, N. (1990). *The Beauty Myth.* London, Chatto & Windus.

Wonderlich, S. A., T. D. Brewerton, et al. (1997). "Relationship of childhood sexual abuse and eating disorders." *Journal of the American Academy of Child & Adolescent Psychiatry* **36**(8): 1107-1115.

Wonderlich, S. A., R. D. Crosby, et al. (2001). "Eating disturbance and sexual trauma in childhood and adulthood." *The International Journal of Eating Disorders* **30**(4): 401-412.

Woods, S. (2004). "Untreated recovery from eating disorders." *Adolescence* **39**(154):11.

Woodside, D. B. (2005). "Commentary: Treatment of Anorexia Nervosa: More questions than answers." *The International Journal of Eating Disorders* **37**:41-42.

World Health, O. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva, World Health Organization.

Wyer, S., L. Earll, et al. (2001). "Deciding whether to attend a cardiac rehabilitation programme: An interpretative phenomenological analysis." *Coronary Health Care* **5**(4): 178-188.

Yager, J., J. Landsverk, et al. (1989). "Help seeking and satisfaction with care in 641 women with eating disorders: I. Patterns of utilization, attributed change, and perceived efficacy of treatment." *The Journal of Nervous and Mental Disease* **177**(10): 632-638.

Yamaguchi, K. (1991). *Event history analysis*. Newbury Park, Calif., Sage Publications.

Yardley, L. (2000). "Dilemmas in Qualitative Health Research." *Psychology and Health* **15**: 215-228

Zeeck, A. and A. Hartmann (2005). "Relating therapeutic process to outcome: Are there predictors for the short-term course in anorexic patients?" *European Eating Disorders Review* **13**(4): 245-254.

Appendix 1: Semi structured individual interview

Exploring the role of psychotherapy in recovery from Anorexia Nervosa: Individual InterviewSchedule.

The purpose of this meeting is for me to hear from you about the role of talking therapy in your recovery from anorexia. Some of the questions relate to your experience of having anorexia, some are about your experience of recovery from anorexia and some questions are specifically about your experience of therapy.

I am interested to hear what you have to say, in your own words. If there is anything I ask you that is unclear, please let me know and I'll try to explain it better. Finally, if there is anything you simply do not feel you can answer, that's ok and we will move on. The interview should take no more than an hour, however if we find that we run over by a small amount, we can either decide to carry on, to meet again or we can decide to leave it there.

Hopefully, between us, we can make the discussion as relaxed and comfortable as possible. Does that sound ok? Do you have any questions at this stage?

Demographic Information.

ID Code: Age: Gender: Ethnic Origin:

1. Having Anorexia.

I am going to start by asking you about having anorexia.

Can you tell me about what happened when you developed anorexia?
(Triggers/ Causes /Perception at the time/Diagnosis, include age, profession of person giving the diagnosis/ Personal reaction, /Reactions of family or significant others/Other types of mental health difficulty?)

Is there anything else you would like to say about having anorexia?

2. Treatment – General.

Now, I would like to ask you about the kind of treatment or treatments you were offered.

What kind of treatment(s) were you offered? *(Include all forms of treatment, number of treatments offered, the professionals involved in the delivery of each of those treatments)*

There are many different kinds of therapy on offer to people with anorexia. Do you know what kind of talking therapy or therapies you were offered?

What was the treatment like? How did you feel about it?

Is there anything else you would like to say about your treatment?

3. Recovery

Now, I would like to ask you about your recovery from anorexia.

Can you tell me about your recovery from anorexia?
(Length of time/ why it took this length of time/ when did it happen/why)

This study is particularly interested in exploring the role of talking therapy in aiding an Individual's recovery from anorexia. From what you have just said it sounds like
1.
2.
3.
4.
5.
(Add as appropriate) have contributed to your recovery.

I'd like to show you something to look at this in more detail (*Go to Recovery Pie Chart)*

Is there anything else you would like to say about recovery?

4. Psychotherapy

I would like to ask you about your experience of talking therapy. Did psychotherapy aid your recovery?

Without asking you to disclose anything you do not wish to about your talking therapy, Can you explain how the talking therapy worked?

Did your talking therapy assist with look again at the Recovery Pie Chart? If so, in what way? If not, why not?

What was helpful about having talking therapy?

What aspect of your talking therapy made the biggest difference?

What, if anything, has stayed with you from your talking therapy? *(What the participant continues to use from)*

Is there anything else you would like to say about your talking therapy?

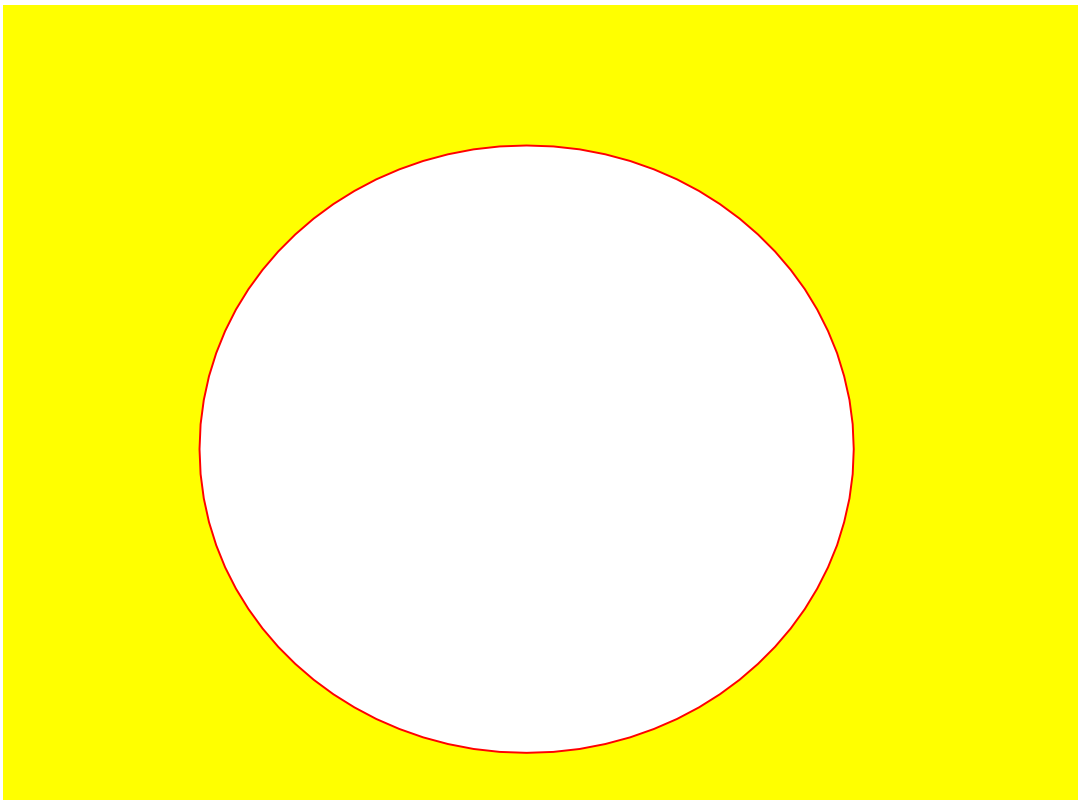
Appendix 2: Blank recovery chart

RecoveryChart

The important things that helped you recover were

1.
2.
3.
4.
5.
(Add as appropriate)

If your recovery was this circle, could you divide your recovery up to show the importance of each of the different things you have identified.



Circle can be divided from 0- 100%

Can you say what made you draw it like you did?

You will see at the bottom of the page it says that the circle can be divided up from 0-100. If the whole circle equals the number 100, what number would you attach to each of these elements? (*Give example).*

Where does your talking therapy fit into your recovery process?

Appendix 3: Recruitment flyer

Have you suffered from anorexia nervosa?

Have you used psychotherapy ("talking therapy") as a way of aiding your recovery process?

If so, would you be interested in participating in a research project looking at sufferers' own accounts of psychotherapy and the role it played in getting better?

If you would like to hear more about this research, please contact Michelle Conway, Researcher and Psychotherapist on **07729132190**, email: michelle.conway@fshc.co.uk, or visit the webpage at **www.health.ed.ac.uk/counsellingstudies/anorexia/**

Appendix 4: Information leaflet for potential participants

"***A qualitative study of people's experience of recovery from anorexia nervosa and the role of psychotherapy in aiding the recovery process".***

Participants are being recruited to take part in a research study exploring sufferers' accounts of recovery from anorexia nervosa and specifically, the role played by psychotherapy in aiding the recovery process. Before you decide if you wish to take part, it is important that you understand why the research is being conducted and what will be involved. Please take time to read the following information with care, and if you wish, feel free to discuss it with friends, relatives, and the researcher. If there is anything that seems unclear, or you would like to know more about, please ask. Take time to consider if you do or do not wish to participate.

Thank for taking the time to read this document.

What is the purpose of this study?
The study aims to develop further understanding about recovery from anorexia nervosa and the role played by psychotherapy in an individual's recovery process.

People who have recovered from anorexia nervosa will be asked to talk about both their experience of recovery and psychotherapy.

The information from this study can help clinicians and service providers further their understanding of what people who have recovered say about their recovery and the way psychotherapy contributed to the recovery.

What will happen if I take part/What do I have to do?
If you agree to take part, you will be asked to meet the researcher who will discuss the study with you in more detail and undertake a questionnaire to ensure that you are a suitable participant for this study. The questionnaire is intended to help identify if a potential participant has not yet recovered from anorexia. If this is the case for you, it would not be possible to participate in this particular study. The researcher will make time to fully discuss the issues that may arise from this. It is important to stress that the questionnaire does not require potential participants to have "no issues" with food, eating and weight. What it will do, is help clarify the extent to which food, eating and weight are still problematic for the individual.

Depending on when you join the study, you will either be asked to participate in two group meetings (focus groups) with other participants and the researcher, or you will be invited to attend an individual interview with the researcher. The focus group meetings will take place at the beginning of the study and will help to inform the themes included in the individual interviews, which will take place at a later stage in the study. However, participants who take part in the focus group meetings will also have the option to take part in an individual interview if they wish to do so. Participants recruited later in the study will only participate in individual interviews.

The researcher will discuss with you a suitable venue for the focus group meeting/or an interview. If you incur any travelling expenses, these will be refunded (within

reason).

What are the possible disadvantages and risks of taking part?
The disadvantages or risks of you taking part are minimal. However, there is a possibility that taking part stirs up distressing memories. If you have any concerns about this or any other questions about participating in the study, the researcher is more than happy to talk to you before you make any decision.

What are the possible benefits of taking part?
In participating in this study, you will have an opportunity to talk about your own experience of recovery from anorexia nervosa and your own experience of psychotherapy. You will also be helping to advance knowledge and understanding of the role of psychotherapy in the treatment of anorexia nervosa. The more known about recovery from anorexia, the better treatments and services can become.

Should I take part?
It is your choice to decide whether you wish or wish not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form, a signed copy of which you will receive. You are free to withdraw at any time and without giving any reason

What if something goes wrong?
Since the research just involves talking there is very little that can go wrong. However, the researcher is ethically and legally obliged to tell you that there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it.

Regardless of this, if you wish to complain about any aspect of the way you have been approached or treated during the course of this study, the normal complaints mechanisms are available to you. With that in mind, it is important to reiterate that it is not anticipated that anything will go wrong.

Will my taking part in this study be kept confidential?
You may find it helpful to tell someone, such a close family member or your GP that you are taking part in this study. I will not inform any of these people unless you ask me to do so. The only exception to this would be if information emerges that raises serious concerns about your health or well-being or the safety of another person. In this event the researcher will discuss with you the best course of action.

What you say during this study will be handled very carefully. In focus groups, participants will be party to one another's contributions. The researcher will also want to share the content of interviews with supervisors and possibly use excerpts from interviews too. However, I can assure you that all information will be anonymised. All information will be held in a secure office in a locked filling cabinet. Instead of your name, you will have a unique research code number.

What will happen to the results of the research study?
It is anticipated that the results of this research study will be published in a scientific journal and the researcher would be happy to inform you of where to obtain a copy of the published results when this happens. The results may also be potentially

presented at conferences. In all instances, you will remain anonymous and all information remains confidential.

Who is organising the research?
I am a postgraduate student at the University of Edinburgh and am doing this study as part of my work for a PhD. My motivation for doing this study comes from my experience of working as a psychotherapist in a specialist eating disorder hospital in Scotland. Through my work and from available research to date, I have found it difficult to know what people who have recovered say about their own recovery process and particularly how psychotherapy helped them. The aim of this study is to help the voices of people who have recovered to be heard and develop further understanding on how psychotherapy aids a person's recovery from anorexia.

Who has reviewed the study?
This study has been subject to review by a Multi-Site Research Ethics Committee in Scotland. The study will also be reviewed on a regular basis by supervisors at the University of Edinburgh

Contact for further information:
For further information about this research study, please feel free to contact Michelle Conway on 07729132190. Alternatively, visit the website on: www.health.ed.ac.uk/counsellingstudies/anorexia/

If you would like further information about eating disorders, you can obtain this from Eating Disorders Association, 103 Prince of Wales Road, Norwich, NR1 1DW, United Kingdom. Helplines 01 603 621 414 (open 9:00 to 18:30 weekdays)
E-mail info@edauk.com web: http://www.edauk.com

In Scotland, you can also obtain information from
Scottish Eating Disorders Interest Group, (SEDIG)
C/o 73 Market Street, Musselburgh, Midlothian, EH21 6PS E-mail: sedig@beeb.net

Appendix 5: Eating Disorder Examination summary

The EDE assesses a broad range of the specific psychopathology of anorexia nervosa, bulimia nervosa and their variants. It generates basic descriptive information about the degree of behavioural disturbance as well as a profile of individual scores on four subscales designed to assess key aspects of eating disorder psychopathology. In addition, the EDE generates information required to make diagnostic grouping of an individual's eating disordered behaviour.

Participant BMI Range: 19.1- 24.4.

Subscale item.	Normative Data.	Participants mean subscale scores.
Restraint. This subscale assesses the amount of restraint a person puts on their eating and includes items such as: restraint over eating, avoidance of eating, food type avoidance, the application of strict dietary rules and desire to have an empty stomach.	Average for AN 3.17 – 3.8 Average for BN 3.14 – 3.7 Average for normal controls 0.64 – 1.14 Average for dieters 1.66	**0.55**
Eating Concern. This subscale measures the levels of concern a person has with regards to the amount they eat and environment in which they eat. It includes items such as: preoccupation with food, eating or calories, fear of losing control over eating, social eating, eating in secret and guilt about eating.	Average for AN 2.17 – 2.8 Average for BN 2.4 – 3.5 Average for normal controls 0.2 – 0.22 Average for dieters 0.5	**0.3**

Weight Concern. This subscale assesses the amount of concern a person has about their weight and includes items such as: importance of weight, reaction to prescribed weighing, preoccupation with weight or shape, dissatisfaction with weight and desire to lose weight.	Average for AN 2.4 – 2.9 Average for BN 3.14 – 3.96 Average for normal controls 0.52 – 1.00 Average for dieters 1.79	**1.14**
Shape Concern. This subscale assesses the amount of concern a person has about the shape of their body and includes items such as: wish for a flat stomach, importance of shape, preoccupation with weight or shape, dissatisfaction with shape, fear of weight gain, discomfort seeing own body, avoidance of exposure of body to others and feelings of fatness.	Average for AN 2.85 – 3.5 Average for BN 3.55 – 4.1 Average for normal controls 0.64 – 1.14 Average for dieters 1.99	**0.71**

Appendix 6: Consent form for research participants: The role of psychotherapy in recovery from anorexia nervosa: Sufferers' perspectives

Please tick the boxes, then sign and date the form at the end.

☐ I agree to take part in this research project.

☐ I confirm that I have read and/ or had explained to me the research information leaflet.

☐ I confirm that I understand the information contained in the research information leaflet.

☐ I understand that taking part in the research project is voluntary and I can change my mind and withdraw my participation at any time, without giving any reason.

☐ I understand that both focus groups and individual interviews will be recorded and transcribed by Michelle Conway, researcher. The transcripts will be shared with two research supervisors at Edinburgh University.

Name ----------

Signature ----------

Name of Person Taking Consent ----------

Signature ----------

Date ----------